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THE RURAL HEALTH CARE CHALLENGE

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

SECOND SESSION

WASHINGTON, DC

PART 1—RURAL HOSPITALS
JUNE 13, 1988

PART 2—RURAL HEALTH CARE PERSONNEL
JULY 11, 1988

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THE RURAL HEALTH CARE CHALLENGE
PART I: RURAL HOSPITALS

MONDAY, JUNE 13, 1988

U.S. Senate,
Special Committee on Aging,
Washington, DC.

The committee met, pursuant to notice, at 9:30 a.m., in room 628, Dirksen Senate Office Building, Hon. John Melcher (chairman of the committee) presiding.

Present: Senators Melcher, Burdick, Breaux, Shelby, Reid, Pressler, Grassley, Wilson, Domenici, and Simpson.

Staff present: Max Richtman, staff director; Chris Jennings, professional staff member; Jenny McCarthy, professional staff member; Kelli Pronovost, hearing clerk; Larry Atkins, minority staff director; and Nancy Smith, professional staff member.

OPENING STATEMENT BY SENATOR JOHN MELCHER, CHAIRMAN

The Chairman. The committee will come to order.

This morning we are meeting on rural hospital issues. Our hearing today will detail from the horse's mouth, that is to say from the rural hospital administrators themselves, about the problems they face, particularly those due to Medicare. We will have a second hearing in July to hear from doctors, nurses, and others on rural health care personnel issues.

It is high time that we paid attention to what is happening to rural hospitals across the country. Among our concerns are the large number of people in rural areas who are elderly, eligible for Medicare, and who depend upon getting health care services in their communities.

Since 1980, 161 rural hospitals have closed across the country. Since 1980—I repeat—161 rural hospitals have closed. That leaves about 2,700 rural hospitals in the United States. Of that number, we find that about 600 are at the make-or-break point, that is, at a point where they are losing so much money that they may have to close. This means that roughly 23 percent of our 2,700 rural hospitals are on or near the brink of closure.

In 1982, the prospective payment system proposed by the Administration recommended that the DRG charges be the same for both rural and urban hospitals. However, that recommendation wasn't followed; instead it was changed.

So, we now find that, between 1984 and 1986, for those hospitals across the country that have lost money under Medicare, 83 percent of them are rural hospitals. This is disturbing to me and to the other members of this committee. We have a real problem across the countryside of America with many of our rural hospitals. We may even lose a large number of them in the next 2 or 3 years.

If that happens, we are very much concerned that there may be no health care provided for people in rural areas. It is this committee's responsibility to determine what can and should be done to prevent this from happening to our older American constituents.

Indeed, it could be a very serious problem, and we are here to find out the facts.

In our second hearing, we will hear from doctors, nurses, and others involved in rural health care personnel issues. That hearing will be later, in July.

I hope out of these combined hearings we can piece together the facts as they affect both Medicare and rural health care and be able to come up with some very solid recommendations for the rest of our colleagues in the Senate.

[The prepared statements of Senators Melcher, Pryor, and Johnston follow:]

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

OPENING STATEMENT

SENATOR JOHN MELCHER
Chairman, Senate Special Committee on Aging

June 13, 1988

THE RURAL HEALTH CARE CHALLENGE: PART 1: RURAL HOSPITALS

Good morning. On behalf of myself and the other members of the Special Committee on Aging, I would like to welcome everyone -- especially those witnesses who have travelled a great distance to be with us today. This morning, we will be taking a close look at the problems facing rural hospitals as well innovative efforts to effectively address those problems.

This hearing is the first of two I will be holding on one of the greatest challenges facing rural America today: ensuring access to health care. The second hearing, scheduled to take place just about this time next month, will focus on health care manpower issues, another major rural health policy concern.

Rural hospitals are the core of the rural health care system. With the elderly making up a large and growing percentage of the rural population, rural hospitals play a particularly vital role in their lives. And for that same reason, Medicare reimbursement is of increasing importance to rural hospitals.

Like never before, our nation's rural hospitals are being challenged. Since 1980, 161 rural community hospitals have been forced to close. And many more than than that -- an estimated 600 out of a total of 2,700 rural hospitals -- currently are near or on the brink of closure.

In its original Prospective Payment System proposal in 1982, the Administration recommended a single DRG price schedule, applicable to both urban and rural hospitals, with an immediate shift to full national rates. Concerned about the implications of such a rapid redistribution of Medicare payments, the Congress adopted separate urban and rural price schedules (standardized amounts) and chose a slow transition to national rates. In retrospect, however, by taking this approach and freezing in reimbursement rates at levels that we now know did not and do not provide sufficient revenue for rural hospitals to be competitive, we enacted a measure that was, and continues to be, discriminatory to rural hospitals.

How have rural hospitals fared under the Medicare urban-rural reimbursement system? In the first three years -- fiscal years 1984, 1985, and 1986 --- of that system, about 83 percent of all hospitals that were losing money under Medicare were located in rural areas. Even more startling, over half of those hospitals losing money were rural facilities with less than 50 beds, and 75 percent of them were rural hospitals with less than 100 beds.

In my own state of Montana, the situation also is very serious. We have a total of 56 hospitals, of which 46 are located in rural communities. The great majority of these rural facilites serve remote or frontier areas of the state. In the last 18 months, there have been 4 hospitals -- all designated as rural by Medicare -- which were forced to close. In 1986, of the 32 rural hospitals with 30 beds or less, 22 were in the red. Even after local governments pumped in money to strengthen their financial situations, half of these facilities still posted operating losses.

There are a number of reasons why rural hospitals, particularly those that are smaller, are disproportionately impacted under Medicare's cost containment initiatives. Rural hospitals have fewer hospital admissions, declining lengths of stay, increasing severity of illness of the patients who are admitted, and lower occupancy rates. Also, they have fewer personnel and specialized services and serve a population that is more likely to be un- or under-insured, as well as older, than average. All these special problems make rural hospitals more vulnerable to experiencing financial losses under Medicare.

Now, some believe that the federal government shouldn't step in to keep rural hospitals from closing. In some cases, when there are a number of hospitals situated in one rural area, a policy argument can be made for a closure in order to strengthen the viability of the other hospitals. However, when there is only one medical facility in a frontier area and its closure results in the elimination of access to desperately needed health care, that situation can be described as nothing less than tragic.

Further, what must not be overlooked in this discussion is the fact that rural hospitals are a major economic mainstay in the community. Often, rural hospitals are the single largest employer in the area, and they are critical to keeping primary care physicians and businesses in the community -- as well as attracting new doctors and businesses into the area.

In recent years, Congress has taken several steps to help rural hospitals. These include a larger hospital update factor for rural hospitals, development of an Office of Rural Health Policy within the Department of Health and Human Services, establishment of a grant program for rural hospitals to provide assistance in restructuring their services to better meet the changing health care needs of the community. But these may not be enough. It may be time to give serious consideration to closing the gap in the Medicare urban-rural differential.

Soon after the conclusion of the July hearing on rural health care personnel issues, I will be releasing a committee print that discusses the range of problems within the rural health care system and options, including narrowing or eliminating the Medicare differential, that should be considered in response. That print also will examine the efforts rural hospitals are making to strengthen their financial standing.

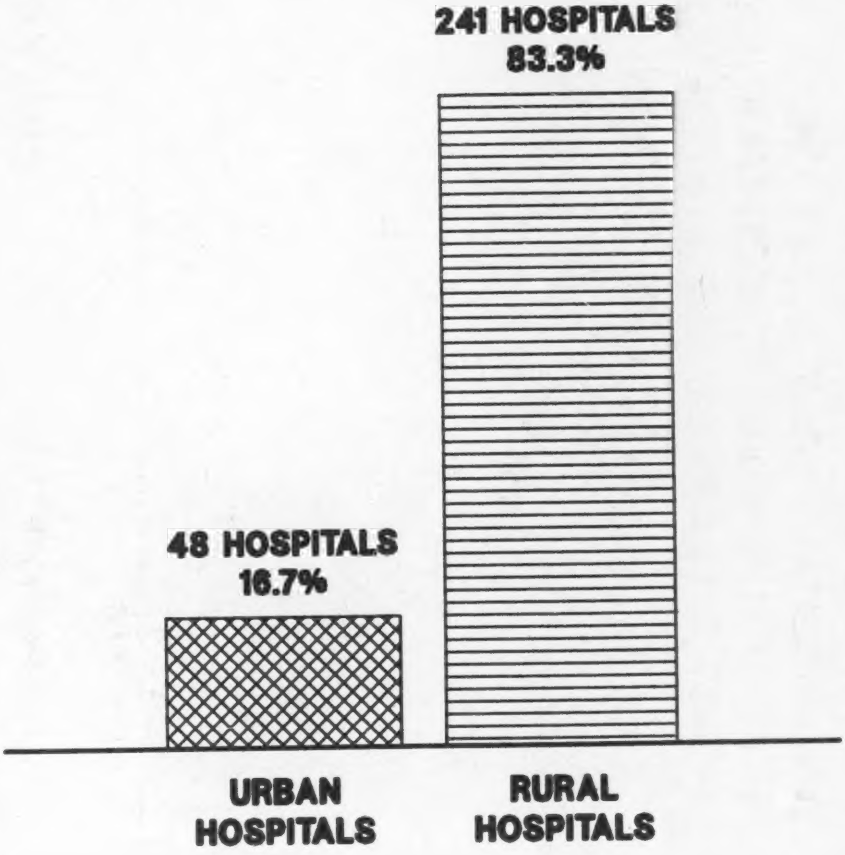
Rural hospitals have sought to improve their financial health through a number of ways. Many have diversified their services, converted a number of their beds to post-acute "swing beds", and established home care and social services. Others have entered into multihospital arrangements to pool resources and ease financial strains.

At the same time, a number of rural hospitals, with the assistance of private foundations, are demonstrating innovative ways to improve their financial viability and to ensure health care access in rural areas. With respect to frontier hospitals, an approach that is receiving attention is a proposal developed by the Montana Hospital Association to down-size facilities that are faced with closure to ensure a medical presence in the community.

In a brief moment, we will be hearing about the difficulties and the promising developments within the rural hospital system. Before we begin, however, I would first like to thank the other members of this committee and their staff for their input into this hearing. I know that many of my colleagues on this committee share my deep concerns over the rural hospital issue, and I hope that this hearing and the Aging Committee report will contribute to efforts to ensure access to health care in rural America.

289 HOSPITALS LOST MONEY UNDER MEDICARE'S PROSPECTIVE PAYMENT SYSTEM IN EACH OF THE FIRST 3 YEARS OF THE SYSTEM (FY 84–86)

WHO ARE THEY?



SOURCE: JUNE 1988 PROSPECTIVE PAYMENT ASSESSMENT COMMISSION REPORT

289 HOSPITALS LOST MONEY UNDER MEDICARE'S PROSPECTIVE PAYMENT SYSTEM IN EACH OF THE FIRST 3 YEARS OF THE SYSTEM (FY 84–86)

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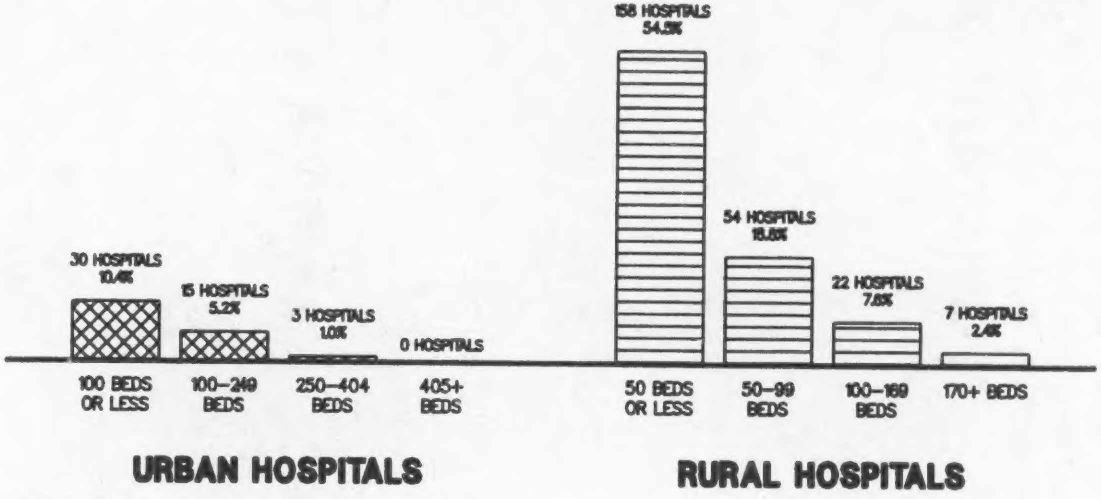

STATEMENT BY THE HONORABLE DAVID PRYOR
at the hearing on
THE RURAL HEALTH CARE CHALLENGE: PART I
U. S. SENATE SELECT COMMITTEE ON AGING

June 20, 1988 9:30 a.m.

Mr. Chairman, I must first take a moment to commend you for scheduling today's hearing on this timely subject. The special problems facing rural health care facilities and providers continue to escalate, and we in the Congress must become more sensitized to these issues.

As the distinguished panel of witnesses this morning will no doubt confirm, the number of rural hospital closings in recent years sends an alarming signal about the future of our rural health care system. Between 1980 and 1985, an average of 36 community hospitals closed annually; in 1986 that number jumped to 71. The figures for 1987 are expected to be worse. Over the last three years, six rural hospitals in my State have been forced to close, and another fifteen are at risk of not making it through 1988. While the Medicare prospective payment system is partly to blame for this discouraging trend, I will be interested to have the thoughts of today's panel on other causes of the erosion of rural health care in our country.

I should mention that last year the Congress did begin to address this dilemma---the final 1987 OBRA package contained several provisions of benefit to rural hospitals, including a larger payment "update" factor than urban facilities. The OBRA '87 package also included a measure I cosponsored, the establishment of a rural health care transition grant program.

I am pleased that while this hearing will examine the difficulties rural hospitals face, we will also be focusing on some of the innovative strategies being developed to meet those special challenges.

Once again, Mr. Chairman, I commend your leadership in calling for this hearing, and welcome our panel of distinguished experts.

STATEMENT OF SENATOR JOHNSTON
THE RURAL HEALTH CARE CHALLENGE
PART I: RURAL HOSPITALS
JUNE 13, 1988

Mr. Chairman, I am pleased that the Committee has scheduled this very timely hearing on rural health care in America. I think everyone realizes that rural hospitals are faced with a unique set of problems that generally are not present in urban hospitals. For example, in most instances, a rural hospital is the only hospital in the community, and oftentimes has a high percentage of Medicare and Medicaid patients. Under the Medicare prospective payment system, these hospitals are being reimbursed at a lower rate than urban hospitals, a situation that is increasingly threatening their ability to remain as viable institutions and one which has led to the closure of 161 rural hospitals since 1980 and has placed 600 more rural hospitals on the brink of closure.

I am concerned about this trend and what it will mean for rural health care, particularly in my home state of Louisiana which has over 70 rural hospitals. We have had 6 hospitals close during the past seven years and many more are near to closing. This problem has been exacerbated by Medicare reimbursement policy and the deep and prolonged recession in the Louisiana economy. Our economy is closely tied to the oil and gas industry and agriculture. As a result of the downturn in these sectors, Louisiana has led the nation in unemployment, often at rates that are twice the national average.

I hope this series of hearings will examine these problems and explore innovative ideas that will allow rural medical communities to continue to provide much needed services to their constituencies. In this regard, I am pleased that the Committee has invited my constituent, Michael E. Cooper, Administrator of the Richland Parish Hospitals to testify and I look forward to reviewing his testimony.

Thank you.

The CHAIRMAN. Senator Burdick, do you have an opening statement?

STATEMENT BY SENATOR QUENTIN BURDICK

Senator BURDICK. Mr. Chairman, I want to thank you for holding this hearing. The hearing certainly demonstrates your concern for the unique needs of older persons in rural America.

As Co-chairman of the Senate Rural Health Caucus, I believe we must make sure that the health care needs of our rural Americans are not forgotten. This hearing allows us to examine some of the many problems in rural America and, more importantly, to begin to identify solutions to these problems.

The health problems of the aged in rural America are of particular concern in my State. North Dakota, as with other rural States, contains a higher proportion of older citizens than States that have many urban centers. Thirteen percent of the citizens of North Dakota are over 65 years of age. These are people who have devoted a great deal of attention to their farms, their livestock, and their families. These are people who played a pivotal role in keeping rural America prosperous. They are the same people who now worry about obtaining basic health care within a reasonable distance from their homes.

They worry about how they can care for spouses who suffer from chronic illnesses when respite care and home health care simply can't be found. Across the country, rural America holds only 12 percent of our nation's physicians and 18 percent of our nation's nurses. In 1986, we saw for the first time more rural hospitals than urban hospitals closing, a trend predicted to continue.

In my home State of North Dakota, two rural hospitals are on the brink of closure due, in large part, to the inequities of the Medicare reimbursement system. The majority of these hospital patients are Medicare recipients, yet Medicare's payment policy is causing them to lose money. It took a year and a half of my office intervening with the Administration to address their problems.

If the Medicare system were more sensitive to the needs of rural hospitals and the rural elderly, that intervention wouldn't have been necessary. The Federal Government has made a commitment to these senior citizens that quality health care will be available to them. Yet, Federal payment policies are threatening that health care system by consistently underpaying rural hospitals, and we are inviting a situation in which the elderly living in rural areas will not have accessible health care. Yet, it is the elderly that require more health care, on the average, than any other segment of our population.

I believe that I can speak for members of the Senate Rural Health Caucus when I say that a health care structure based on large models simply will not work in rural America. We need to find positive alternative strategies for meeting the health care needs of rural America that fit the people of rural America and not the other way around.

Good health care systems for rural America should have a flexibility, an ability to adapt to the unique needs of rural Americans.

A good solution will not be one solution but a range of alternatives that fit the various patterns found in rural living.

I believe that the future will bring significant change to health care in rural America. My hope is that this hearing will provide us with strategies for restructuring that health care system in a positive way. To do less is to allow a continuing decline in access to quality health care.

I look forward to listening to the testimony to be presented here today and to learn more about ways in which the Federal Government can demonstrate its support for and commitment to the health of the aged and of all people in rural America.

Thank you, Mr. Chairman.

The **Chairman**. Thank you, Senator Burdick.

Senator Grassley, do you have an opening statement?

STATEMENT BY SENATOR CHARLES GRASSLEY

Senator **Grassley**. Yes, Mr. Chairman, I do.

Rather than just a simple thank you to you, Mr. Chairman, for holding this hearing, I want to say I am thankful for the reason that this is a topic that constantly comes up in my town meetings in my State of Iowa. So, it is a very current one all through rural areas.

I guess maybe I am thankful, too, because I feel some frustration that what little bit we have done within the Congress to make up the difference between the rural and urban differential either has not done as much good as we thought it would do or else, if it has been done, it hasn't been enough to be recognized at the grass roots.

So, I say in this whole process there is good news and there is bad news. The bad news is noted recently in a report issued jointly by the National Rural Health Association and the National Association of Community Health Centers that health care in rural areas is not what it should be, and there appears to be a clear and present danger that it could deteriorate even further.

Their report reminded us that in rural parts of America, there is more poverty, less health insurance coverage, less Federal spending on health per capita than in the urban areas, the liability insurance problem probably has a greater impact on the availability of certain kinds of health care, and there is a shortage of health personnel, including nurses, and there remains a clear and inequitable payment differential between urban and rural hospitals in the Medicare prospective payment system that compounds the financial difficulties of a rural hospital.

The good news now is that the Congress has begun to recognize the special health care problems of rural communities and has taken some steps to address these problems. In the last year with the reconciliation bill, we in Congress created the Office of Rural Health Care which will serve as a focus in the executive branch for systematic review of the health policy of the Federal Government as it affects rural areas.

The National Advisory Committee for the office has just been chosen, and I am very pleased that former Iowa Governor Bob Ray has been named as chairman. The Governor has been very involved in health policy debates in Iowa, and I think he is going to bring considerable knowledge and a high degree of commitment to the cause of high quality health care in rural areas.

The Office of Rural Health was not the only result of last year's reconciliation bill, however. Among other things, we provided a larger DRG update factor for small rural hospitals than we did for urban hospitals, established a transition grant program to help rural hospitals adapt their programs to changing circumstances, and we expanded the hospital swing bed program. We required the Health Care Financing Administration to dedicate 10 percent of its research monies to rural health topics.

Many of these proposals were championed by the Senate and House Rural Health Caucuses already referred to by Senator Burdick. The activity of these groups, I think, has been important in helping to get the Congress focused on the problems of health care in rural areas.

I am pleased to see, Mr. Chairman, that under your leadership, the Special Committee on Aging is joining the effort to identify the major health care problems facing rural communities and, most importantly, to define solutions to those problems. That is entirely appropriate, because there is a higher percentage of retired people in rural areas of America.

It seems to me that this line of inquiry is appropriate. As we all know, there are many reasons why deterioration of health care in rural areas will have a disproportionate effect on older people.

In many rural States such as my own, a very high proportion of the population is elderly. I think it is third of all the States in the nation as a percentage.

A corollary to this is that the Medicare beneficiaries of this group constitutes a very large part of the rural hospital patient load. In Iowa, for instance, in 1986, Medicare beneficiaries accounted for 30 percent of total hospital discharges and 37 percent of inpatient days.

Furthermore, many of the hospitals in rural communities are small. In my own State, 67 of a total of 126 community hospitals, or about 53 percent have under 50 beds. Another 29, or 23 percent of the total have between 50 and 99 beds. These hospitals must pay for their fixed costs with a relatively much smaller average patient census, and thus are extremely sensitive to changes in patient volume.

And it probably doesn't need to be emphasized to this audience or to the members of this committee, that these hospitals are very sensitive to Federal Medicare policies.

Insofar as these smaller rural hospitals become less viable, and insofar as some number of them fail and disappear, health care for the large proportion of the rural population which is elderly can become less accessible.

We have increased the visibility of these issues in Congress, Mr. Chairman. What remains now is to identify the next steps that we need to take to ensure that we maintain appropriate and high quality health care in our rural communities and to move the Congress to implement these changes.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Grassley.

Senator Shelby.

STATEMENT BY SENATOR RICHARD SHELBY

Senator SHELBY. Thank you, Mr. Chairman.

Mr. Chairman, I would like to begin this morning by commending you and your staff for holding this hearing today. I think it is very important.

As a nation, we have committed ourselves to the ideal of universal access to basic health care services. To keep that commitment to rural citizens, I believe we must recognize the unique stresses on rural health care delivery systems.

Small rural hospitals are the key to a strong rural health care system. In addition to basic acute care, these hospitals often provide other valuable health services to the community such as respite care, nursing care, well child clinics, preventive care, and the list goes on.

Frequently, these hospitals are the largest employers in their communities. Over the last several years, the rural unemployment rate has been consistently higher than in urban areas. When a hospital closes, Mr. Chairman, many jobs are lost, further contributing to an already deteriorating rural economy.

There is growing evidence that our rural health care system is under severe strain. Rural hospitals are closing at record rates. Since 1980, 161 rural community hospitals have closed their doors, and the remaining 2,700 rural hospitals across the country are experiencing such financial stress that closure may be imminent for many.

Like in other areas, access to community based, high quality basic health care services is at risk in rural Alabama. Of the 144 hospitals in my State, 70 are rural, with the majority having fewer than 50 beds. Last year, 75 percent of these rural hospitals reported an operating loss.

This situation is not unique to my State. Across the country, hospitals are struggling with inadequate Medicare and Medicaid reimbursement, Federal cost cutting initiatives, declining admissions, and an increasingly competitive health care environment.

There are a variety of reasons, Mr. Chairman, for the precarious situation in which our rural hospitals find themselves today as compared to their urban counterparts. Rural hospitals tend to be smaller, have fewer patients, provide fewer specialized services, and often serve an older population.

It has been estimated that one-third of our nation's elderly live in rural areas, and rural practitioners often treat patients who are sicker, as it is reported that rural Americans have disproportionately high rates of serious, chronic illness. Due to the higher percentage of elderly as a portion of the total population in rural areas, rural hospitals are especially dependent upon Medicare. They lack the volume and the mix of patients to balance shortfalls in Medicare reimbursements and are thus hard pressed to pay the salaries that will attract and retain professionals.

Rural hospitals are in particular financial peril, Mr. Chairman. Recent reports show that the majority of rural hospitals in my State of Alabama are experiencing negative Medicare operating margins. Rural hospitals treat fewer private paying patients and treat a disproportionately high percentage of Medicare patients.

Rural citizens, as a group, have a 15-percent higher rate of uninsuredness than the U.S. average and a 24-percent higher rate than their urban counterparts. Also, 75 percent of the rural poor do not qualify for public assistance.

The dependence of rural hospitals on Medicare as a major payment source has become particularly keen since the implementation of the prospective payment system in 1984. Nearly twice as many hospital closures were reported in 1987 as in 1984.

Inadequate reimbursement granted to hospitals for Medicare patients can ultimately raise concerns about quality and access to health care as reduced payment rates force hospitals to cut down on staff and close unprofitable services. This is particularly troublesome for rural hospitals.

The possibility of numerous closures is becoming a reality across the country. In Alabama alone, the Alabama Hospital Association reports that as many as 10 facilities may close this year. All of them will be small, and all of them, Mr. Chairman, will be rural.

For the most part, society in general and many in government usually think it is cheaper to provide care in rural areas than in urban. In fact, however, the greater differences, geographic barriers, and sparse populations actually make the provision of health care more expensive in rural areas.

Rural providers are finding it increasingly difficult to attract and to retain health professionals, in part due to substantial differentials in urban versus rural Medicare reimbursement rates. Many rural hospitals contend that they much pay more for qualified hospital staff than the nearby urban hospitals since they both draw from the same geographic labor pool.

Rural hospitals in remote areas argue that they sometimes pay increasingly higher salaries to attract specialized staff such as intensive care nurses to their community. As hospitals are labor intensive, Mr. Chairman, this magnifies the problem of making health care services locally accessible.

Although the number of U.S. physicians may be sufficient for the nation, there are dramatic shortages in many rural areas. Studies have shown that when a small rural hospital closes, the community often loses its physicians and has difficulty attracting new ones because doctors often will not practice in an area without a hospital.

Rural hospitals in Alabama also report a severe shortage of nurses, pharmacists, physical therapists, lab technicians, and other allied health professionals.

There is no one strategy or one solution to the problems faced by rural hospitals, Mr. Chairman. Foremost in our minds should be the need to study equity concerns of small or rural hospitals with respect to the Medicare prospective payment system and other financial constraints that inhibit such hospitals' ability to provide needed health care services to their communities.

Access to and availability of basic health care services in our nation's rural areas must be maintained if we are to keep the commitment to our rural residents.

Thank you, Mr. Chairman.

The **Chairman**. Thank you, Senator Shelby.

Senator Wilson, do you have an opening statement?

STATEMENT BY SENATOR PETE WILSON

Senator **Wilson**. Mr. Chairman, I will just make a couple of observations.

First, I also want to commend you for convening these hearings, this one and the next one which will focus on rural health care. I must say I am impressed with the scholarship I have heard from my colleagues, and I think one of the points made by Mr. Grassley deserves particular attention—a point common to his State and probably to all rural States. Indeed, it is common to health care across the country.

There is a tremendous nursing shortage, and I hope our hearings will focus on this critical issue—I note that the second hearing next month will have manpower as its focus. Specifically, there is a real irony in an INS regulation that threatens to aggravate what is already a very perilous situation.

Because of the nursing shortage in hospitals throughout America, we have become increasingly dependent upon foreign trained nurses. Yet, under the INS regulations of which I spoke, we are threatened with losing some of the most competent of these foreign trained nurses, those that have been trained in England, Ireland, Mexico, and the Philippines. They are threatened with being required to return to their native lands because their visas are expiring, even though they have been in operating rooms and intensive care units doing the kind of nursing which is critically needed.

I think it would be not just interesting but vital in either this hearing or the next one to focus on the extent to which that INS regulation threatens rural health care.

Beyond that, I think that your opening statement, Mr. Chairman, and that of Mr. Shelby and Mr. Grassley have remarked properly on the inadequacy of Medicare reimbursement to rural hospitals in particular and on the error which we made with the best intentions in the world in seeking to differentiate a cost schedule and a reimbursement rate schedule between urban and rural hospitals.

The closure of these hospitals has all of the impacts that have been so eloquently described by Mr. Shelby. These closings have been a problem for years and years, long before anyone ever dreamed of Medicare. How do we get adequate health care and how do we lure physicians and nursing personnel into rural areas where there is a critical need for them?

It would appear that we have, through this DRG, aggravated that situation. Obviously, it is necessary that we make some effort to provide special incentives to nurses and physicians, because it is clear that rural health care is suffering an even greater crisis than that in the cities.

Thank you, Mr. Chairman.

The **Chairman**. Thank you, Senator Wilson.

Senator Breaux.

STATEMENT BY SENATOR JOHN BREAUX

Senator **Breaux**. Thank you, Mr. Chairman. I will be very brief.

I also would commend you for having these hearings. It is under your leadership that we are beginning to look into these problems, particularly in the rural areas in which they are very serious indeed.

I agree with Senator Wilson. The problems in the rural hospitals seem to be more pervasive and more serious than they are in the urbanized areas, although we have problems there, too. It is a problem of payments. It is a problem of providing qualified and adequate professionals to serve in those hospitals.

I know in Louisiana we have had some very desperate situations of rural hospitals just willing to have anybody work there because they can't find the professional people that they need. It is a very serious problem, and I am sure it is the same throughout all of America.

We have a very good witness list and I am anxious to hear comments on what the problems are first hand. I would mention Mr. Michael Cooper who is our administrator of two hospitals which are probably very typical of the rural hospitals we have around the country, one a 75-bed hospital and another a 43-bed hospital in rural Louisiana. He brings a great deal of talent to this panel this morning because of his history as an administrator and working with rural hospitals throughout Louisiana. I am anxious to hear Michael's testimony as to what he has to say, and I look forward to hearing the other witnesses also.

Thank you, Mr. Chairman.

The **Chairman**. Thank you, Senator Breaux.

Senator Domenici.

STATEMENT BY SENATOR PETE DOMENICI

Senator **Domenici**. Thank you, Mr. Chairman.

I just want to commend you for calling the hearings. Fifty percent of our hospitals are rural, defined as 50 beds or less, and my State is no exception. Over 50 percent of my State's hospitals thus defined are rural. They are having as difficult a time as expressed here by Senators who have been speaking of the plight of rural hospitals.

I concur that we have to do something about it, but I also agree that it is a multi-faceted problem all the way from where we are going to get the staffing for them to where we are going to get the reimbursement money for the programs that we have that are already within them. Nonetheless, we must move in a forthright manner to try to define the problems and attempt to solve them.

I thank you for calling the hearings and look forward to hearing the witnesses.

[The prepared statement of Senator Domenici follows:]

STATEMENT OF SENATOR PETE V. DOMENICI
JUNE 13, 1988
AGING COMMITTEE HEARING: THE RURAL HEALTH CARE CHALLENGE:
PART 1: RURAL HOSPITALS

MR. CHAIRMAN, THANK YOU FOR HOLDING THIS, THE FIRST OF TWO VERY IMPORTANT COMMITTEE HEARINGS ON RURAL HEALTH. I ALSO WISH TO ADD MY THANKS TO THE DISTINGUISHED WITNESSES WHO HAVE AGREED TO APPEAR HERE THIS MORNING.

TODAY WE WILL EXAMINE SOME OF THE MOST CRITICAL ASPECTS OF WHAT SOME HAVE CALLED "THE CRISIS IN RURAL AMERICA" -- ACCESS TO HEALTH CARE, PARTICULARY FOR OUR OLDER AMERICANS, AND THE PRECARIOUS FINANCIAL STATUS OF RURAL HOSPITALS. IN TODAY'S HEARING WE WILL EXPLORE THESE ISSUES, WHICH WILL, MORE IMPORTANTLY, LEAD US INTO TO A DISCUSSION OF ALTERNATIVES FOR MAINTAINING ACCESS TO CARE AND PREVENTING THE FINANCIAL DECLINE OF RURAL HEALTH CARE FACILITIES.

CURRENTLY, ABOUT HALF OF AMERICA'S HOSPITALS ARE RURAL. MANY SMALL RURAL HOSPITALS (ESPECIALLY THOSE WITH FEWER THAN 50 BEDS) ARE IN SERIOUS FINANCIAL DIFFICULTY. AND MORE OFTEN THAN NOT, THESE SAME SMALL HOSPITALS ARE A COMMUNITY'S ONLY SOURCE OF HEALTH CARE.

THIS SITUATION EXISTS IN NEW MEXICO, AS I KNOW IT DOES IN JUST ABOUT EVERY STATE IN THIS NATION. ALMOST 40 PERCENT OF NEW MEXICO'S HOSPITALS CAN BE DEFINED AS RURAL AND IN MANY INSTANCES THEY ARE THE COMMUNITY'S SOLE SOURCE OF CARE. MANY OF THESE HOSPITALS ARE LOCATED IN "FRONTIER" AREAS -- WITH POPULATIONS OF LESS THAN 6 PERSONS PER SQUARE MILE. THESE HOSPITALS TEND TO SERVE A POPULATION THAT MAY BE OLDER, POORER, AND LIKELY TO BE UNDER- OR UN- INSURED. FURTHERMORE, MANY OLDER RURAL AMERICANS FACE ADDITIONAL BARRIERS TO HEALTH CARE -- SUCH AS, LIVING ON A FIXED AND LIMITED INCOME, AND FINDING ADEQUATE TRANSPORTATION. THESE ARE DISTURBING FACTS, ESPECIALLY WHEN THESE HOSPITALS CLOSE -- WHERE DO THESE PEOPLE GO FOR CARE?

RURAL HOSPITALS ARE USUALLY SMALLER, MORE ISOLATED, AND OFFER FEWER SPECIALIZED SERVICES THAN URBAN HOSPITALS. HOWEVER, THEY MUST STILL BE PREPARED TO DELIVER CARE 24 HOURS A DAY AS WELL AS COVER ALL THEIR OPERATING EXPENSES.

UNDERSTANDING THE PLIGHT OF THE RURAL HOSPITAL REVEALS A VERY COMPLEX SITUATION. ALL OF US WOULD AGREE THAT RURAL HOSPITALS DIFFER FROM THEIR URBAN COUNTERPARTS. IT IS PRECISELY THESE DIFFERENCES THAT CAUSE THEM TO BE SO VULNERABLE TO EVEN THE MOST SUBTLE OF CHANGES IN THE GENERAL ECONOMY OR THE HEALTH CARE INDUSTRY.

THE UNIQUENESS OF RURAL HOSPITALS CHARACTERISTICS COUPLED WITH RECENT TRENDS IN HEALTH CARE DELIVERY --FEWER ADMISSIONS, SHORTER LENGTHS OF STAY, INCREASING SEVERITY OF ILLNESS, AND VARIOUS COST CONTAINMENT INITIATIVES -- MAKE IT EXTREMELY DIFFICULT FOR THESE INSTITUTIONS TO MAKE ENDS MEET AND PROVIDE NEEDED HEALTH CARE SERVICES TO THEIR CITIZENS.

I AM VERY CONCERNED ABOUT THESE PROBLEMS OF RURAL AMERICA. I HAVE WORKED TO IMPROVE THE VIABILITY OF OUR RURAL HEALTH CARE SYSTEMS.

I WORKED TO PASS MANY OF THE RECENT CONGRESSIONAL ACTIONS AIMED AT LESSENING THE MEDICARE PAYMENT INEQUITIES FELT BY RURAL HOSPITALS AND SOME PROGRAMMATIC CHANGES TARGETED AT RURAL PROBLEMS, SUCH AS THE ESTABLISHMENT OF THE OFFICE OF RURAL HEALTH POLICY WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

I REALIZE THAT ADJUSTMENTS IN THE MEDICARE PROSPECTIVE PAYMENT SYSTEM ALONE WILL NOT SUSTAIN THESE RURAL HOSPITALS. NO LONGER WILL TREATING THE SYMPTOMS OF THE RURAL PROBLEMS WITH ONLY DOLLARS BE SUFFICIENT, WHAT IS REQUIRED IS THE DEVELOPMENT OF COMPREHENSIVE SOLUTIONS -- THAT REACH INTO THE ECONOMIC, EDUCATIONAL, AND SOCIAL INFRASTRUCTURES OF OUR RURAL COMMUNITIES.

I LOOK FORWARD TO A VERY INFORMATIVE DISCUSSION AND AM ANXIOUS TO HEAR FROM OUR WITNESSES ABOUT THEIR VIEWS ON RURAL HEALTH CARE, WITH SOME SPECIFIC ATTENTION GIVEN TO THE FINANCING MECHANISMS AND DELIVERY OF QUALITY HEALTH CARE.

The CHAIRMAN. Thank you, Senator Domenici.

Senator Reid.

STATEMENT BY SENATOR HARRY REID

Senator REID. Mr. Chairman, thank you very much.

The first political elective job that I held was as a member of the board of trustees of the largest hospital district in Nevada. Since that time, I have watched with interest what has happened to hospitals in Nevada. Based on the statements made by other Senators here today, it is not only a Nevada problem, it is a nationwide problem.

We have all watched—it is obvious—the hospitals struggle in rural America. I can say that in Nevada that is an understatement. The Schurz Indian Health Services recently closed, leaving many people without the care they need. Further, South Lyon Community Hospital is operating at a crippling yearly deficit—it will close soon if help doesn't arrive.

I think it is also of note that it would be difficult for all the States represented here today to find a new hospital that has been developed anyplace in rural America in recent years. We are talking about saving those that we have. Building new hospitals is almost a thing of the past, and that is wrong, because there are places in rural America that are growing at rapid rates, such as Elco, NV, but there are few new or expanding hospitals. The entire health of rural America is at risk.

I think it is worth commenting on something that Senator Wilson mentioned about the nursing shortage. Just to elaborate on what he said, it is disturbing, Mr. Chairman, to note that there are nurses working in the United States that are being sent back to their various home countries with, many times, no places to work when they return. They are needed here. It is ironic that we are having trouble keeping them here due to our immigration laws. The irony is most strong in the fact that those same immigration laws are responsible for keeping here non-American citizens charged with crimes. We can't get rid of those we don't want, and cannot keep those we do want. It is an interesting dichotomy we find ourselves in.

We have all acknowledged that we have to rearrange priorities, and we talk about this a lot, but when it comes to the health of people, I think talk is not enough. We have to look very closely at the problems facing rural health care facilities and act on our findings.

I appreciate your holding the hearing, Mr. Chairman. I look forward to the testimony today.

The CHAIRMAN. Thank you very much, Senator.

The first witness this morning is Mr. Sam Cordes, who is a member of the National Advisory Committee on Rural Health and a professor at the University of Wyoming.

Doctor, welcome to the committee. Please proceed.

STATEMENT OF SAM M. CORDES, PH.D., MEMBER, NATIONAL ADVISORY COMMITTEE ON RURAL HEALTH, AND PROFESSOR, UNIVERSITY OF WYOMING

Mr. **Cordes**. Thank you, Mr. Chairman, for, number one, holding these hearings and, number two, inviting me to participate in these hearings.

I would agree with Senator Grassley that these hearings are part of the good news in terms of rural health care. There are other parts to the good news. Others, that he also mentioned were the establishment of the Office of Rural Health, the National Advisory Committee to Secretary Bowen on rural health care issues, and the forthcoming funding for rural health care research centers around the country.

However, with the good news, there is also the bad news, and the bad news, of course, is the crisis that rural health care is facing, in general, and rural hospitals, in particular. The situation is indeed grim, and I feel hospitals are the cornerstone of the rural health system. As was mentioned, when the hospitals go, the physicians go. When the physicians go, the pharmacists go, and so on down the line.

Other witnesses this morning will deal more specifically with some of the technical aspects of rural hospital reimbursement, and some of the innovative things that some hospitals are doing in different States. I was asked to provide more of a backdrop, not just for this hearing but for the one next month as well. Sketching out the details will be left to the other witnesses. I will describe the general environment associated with rural America, and how health care relates to the broader theme of rural development—an overlooked item that I think is very important.

I think it is important to understand the rural environment for one fundamental reason. There is a lot of misconceptions about rural America, and if you have misconceptions about it, then you are going to have misguided rural policies.

The rural environment has changed dramatically in the last decade or two. Let me share with you what I call six major myths about rural America.

One myth is that rural America is shrinking. That is not true. There are 60 million people living in rural America today. That is more than there ever has been, ever in this nation's history.

Myth number 2: Rural America is synonymous with farming. Rural America is not synonymous with farming. In fact, less than 10 percent of rural Americans live on farms.

Myth number 3: Non-metropolitan America is synonymous with natural resource industries, including agriculture, forestry, fishing, and mining. In 1940, that was true. Then, about 4 out of every 10 jobs in non-metropolitan America were in these extractive or natural resource industries. Today, the largest employer in rural areas is manufacturing.

Myth number 4: The industrial structure of rural America bears little resemblance to the industrial structure of metro America. Again, there was a time when that was true, and the time in which that was true was when rural was synonymous with farming. If you look at the occupational categories, today you will be shocked, I think, to see that the overall pattern of employment in rural America is really quite similar to that in urban America.

The fifth myth is that rural America is isolated and insulated. Instead, what is true of local rural economies is that they are very specialized and interdependent with national and global economies. Because rural economies are very specialized in a particular activity, that means they are also very vulnerable to these national and international forces.

Urban areas, on the other hand, are not specialized economies, and when one particular sector is in trouble, the slack will be picked up elsewhere.

In the case of a particular type of rural economy, say agriculture, when you have a change in the strength of the dollar and those kinds of things, it sends shock waves through those local economies that have specialized in agriculture.

This general concept also applies to health care. While we have targeted programs to rural areas, some of the most serious problems relate not to the targeted programs, but to the general health policy of the country such as Medicare. Medicare was never intended as a rural specific program, but what happens with the reimbursement rates may have more effect on rural hospitals than a program that is targeted specifically to rural hospitals.

Myth number 6 is that rural America is homogeneous. Rural America is very diverse and much more so than urban America. I think the important implication here is for policy. Specifically, health policies and programs that work in one part of rural America will not work somewhere else.

For example, in the rural South, the problem, in large part, is one of rural poverty. In the rural West, except for the Hispanic populations and the Native American populations, that is not so much of a problem as is sheer distance. These are two very different problems needing two very different kinds of solutions.

So, my message is that we have to have flexibility in rural health policy and that a single rural health policy makes absolutely no sense at all.

While the six misperceptions or myths about rural America are important, there is something equally important that is not a myth: and that is, of course, that there are serious problems throughout the entire rural economy, as well as with the rural health care system. Let me just spend a couple of minutes sketching out how I see the relationship between rural health care and rural economic development.

One consideration is that health care and hospitals are important in attracting industries, businesses and community residents into rural areas. I want to emphasize the community residents.

Today, one out of three dollars of personal income in the U.S. comes in the form of what we call passive income—dividends, rents, transfer payments, social security, and so on. Oftentimes, passive income is tied to the elderly population, and this means the elderly population represents an important economic base for rural communities.

If you don't have adequate health care systems in place the resident population may leave and the community will not be able to attract new residents with more dollars to spend in the depressed rural economies of America.

Another relationship was mentioned by Senator Shelby. He noted the important employment aspects associated with the delivery of health care. The hospital usually is the largest employer in a rural community.

The most common example is the community hospital serving one locale. The more grandiose version is when hospitals serve as an economic base because they serve a much larger area.

There are limits to how far the grandiose care can be pursued but real examples do exist. Certainly, the Marshfield Clinic in Marshfield, Wisconsin and the Mayo Clinic in Minnesota are situations where the health care industry is the economic base of the community. More recently, and on a smaller scale, drug and substance abuse centers that cater to the urban elite have been established in rural areas as part of a larger economic development strategy.

Finally, hospitals and other health care facilities represent an important source of investment funds for the local community. Hospitals need to hold a considerable amount of cash and short-term assets on hand in local financial institutions to take care of their labor and payroll needs, and other needs. These funds also become available for local investments.

Now, having emphasized the important role of health care services and hospitals in rural economic development, I want to close by saying that I don't think we should lose sight of the fundamental reason we need decent health services in rural areas. The fundamental reason is not rural economic development. Instead, the fundamental reason is to enhance the quality of life and provide equal opportunity to those people who live there.

I have been struck recently by the notion of postal services. Two hundred years ago, and written into the Constitution is a provision to provide postal services to all Americans. No matter where you live in rural America, even in the most remote, and most isolated parts of Alaska, Montana, and Wyoming, you will get mail. That is just a guarantee.

Now, it may not be Federal Express, but there will be some minimal set of postal services available.

We have not made that commitment in health care, and I find that distressing, and I think that is an interesting analogy that we should think about.

Thank you.

[The prepared statement of Mr. Cordes follows:]

THE CHANGING FACE OF RURAL AMERICA

AND

THE ROLE OF HEALTH SERVICES IN RURAL DEVELOPMENT

by

Sam M. Cordes
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Testimony Presented to Senate Special Committee
on Aging

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NOTE: The views expressed here are the author's and do not represent the University of Wyoming.

INTRODUCTION

Typically, discussions about rural health and rural hospitals take for granted that everyone has a good understanding of the social and economic fabric of rural America. Obviously, such an understanding is essential if discussions and policies associated with any particular aspect of rurality, such as education or health care, is to make any sense. It has become increasingly apparent to me that tremendous misperceptions exist about today's rural America. My concern is that these misperceptions will result in misguided policy.

Today, I will divide my remarks into two parts: first, I wish to dispel some of the myths that exist about rural America; and, second, I wish to comment on the contribution health services can make to rural development.

SIX MYTHS ABOUT RURAL AMERICA

Myth 1: Rural America is Shrinking

In 1984, over 60 million people lived in rural areas (people living in towns of less than 2,500 population or in the open country). Never had more people lived in rural areas.

Myth 2: Rural America is Synonymous With Farming

Although the rural population has been growing steadily, the farm population has been declining steadily. Today, less than 10 percent of the rural population live on farms.

Myth 3: Nonmetropolitan America is Synonymous With Natural Resource Industries (agriculture, forestry, fishing, and mining)

In 1940, natural resource industries provided more than four jobs out of every ten in nonmetropolitan areas; but by 1980, these industries produced fewer than one job in ten. Today, the largest employer in nonmetropolitan areas is the manufacturing sector.

Myth #4: The Industrial Structure of Nonmetropolitan America Bears Little Resemblance to the Industrial Structure of Metropolitan America

The overall industrial structure between rural and urban America is quite similar. Employment in both metro and nonmetro areas is characterized by private wage and salary workers, although this proportion is somewhat higher in metro areas than in nonmetro areas (78.0 percent compared to 70.8 percent). Within the wage and salary category, a somewhat greater proportion of nonmetro employment compared to metro employment is associated with goods-producing industries. Conversely, a somewhat small proportion of nonmetro employment is associated with service-producing industries. Self-employment in nonmetro counties is significantly higher than in metro counties, but is a relatively small proportion of overall employment in both types of counties.

Myth #5: Rural America is Isolated and Insulated

A common perception about rural America is that it is somewhat outside the mainstream of modern society, and that its basic structure remains fairly stable. This perception, like most of the other perceptions about rural America, includes more fiction that fact.

From the standpoint of economics, any particular rural area tends to specialize in a single type of economic activity. Moreover, many of today's specialized rural economies are tied closely to international forces. For example, in the early 1980s, the strengthening of the dollar, a world-wide recession, and the growing competitiveness of newly industrialized countries (e.g., Brazil, Taiwan, and Hong Kong) worked against several rural industries that tend to export heavily and/or face substantial amounts of foreign imports. Included in this list were manufacturing, energy, forestry, and agriculture.

Because most local rural economies are highly specialized economies, when the singular primary economic activity is under stress, other industries are not available to take up the slack, as typically happens in a larger urbanized economy.

The institutional structure within which rural America operates has changed substantially. For example, "deregulation" and "privatization" have been major national policy themes in recent years, and nowhere have these impacts been greater than in rural America.

Some authorities believe the deregulation of the banking industry has forced businesses in many rural areas to pay higher interest rates.

Similarly, the deregulation of the transportation industry appears to have had negative consequences for rural areas. In the case of air service, the number of departures from hub cities since deregulation has increased much more rapidly than have departures from nonhubs (small communities). Indeed, in the nonhub communities that were not designated as "essential air service" communities, the number of departures has decreased by more than 50 percent since deregulation. Additionally, changes in air fares have placed smaller communities at much more of a cost disadvantage relative to larger communities than was the case prior to deregulation. Freight rates in the trucking industry have risen most noticeably in remote places. In the case of bus service, more than 3,000 small towns and cities have lost service since bus deregulation began in 1982.

In sum, a major problem in yesterday's rural America was isolation--physical, social, economic, and cultural. Although isolation of various types is still an issue, especially in certain regions (e.g., geographic isolation continues to be a major issue in the Western "frontier" counties); isolation has given way to interdependence. In other words, most of the problems faced by today's rural America are precisely because the rural economy and its institutions are inextricably interwoven with the national and international scene. Hence, a war in the Persian Gulf that drives up the price of oil will certainly have much more impact on the economy of an energy-dependent community in Wyoming than will a rural jobs program. Similarly, current Medicare reimbursement policies may be at least as effective in closing rural hospitals as the Hill-Burton Act was in constructing these same hospitals.

Myth #6: Rural America is Homogeneous

Probably the most prominent characteristic of rural America is its diversity, and the differences among nonmetro areas are almost surely greater than the differences among metro areas. Indeed, when one disaggregates the nation's rural population or its nonmetropolitan counties, the striking characteristic is not the similarity that exists. Instead, the striking characteristic is the dissimilarity or diversity within rural America. For example, in 1980, the population of the smallest nonmetro county in the U.S. was 91 persons (Loving County, Texas), and the population of the largest nonmetro county was 155,435 (San Luis Obispo County, California). As another example, a substantial number of nonmetro counties have no physicians, and therefore a physician-to-population ratio of zero. On the other hand, Montour County, Pennsylvania, has 254 physicians, giving it a standardized physician-to-population ratio of 15,232 per 100,000. This ratio is not simply the highest among nonmetro counties, it is also far above the ratio found in any metro county in the U.S.

HEALTH SERVICES AND RURAL DEVELOPMENT

At the moment, there is considerable interest in rural development. Interest in this area has fluctuated over the years, with the last surge of interest in the late 1960s when a National Advisory Commission on Rural Poverty was established. The need for rural development is apparent in that the nonmetro population, in comparison with the metro population, tends to be disadvantaged in a number of ways.

Health services fit into the rural development scheme in at least two distinct ways. First, health services may be important in attracting both employers and community residents. The potential positive impact on employers occurs in two ways. One way is through the formation of "human capital." Human capital is an economic development term that treats humans as productive assets; and investments in education, health care, etc., are expected to yield dividends in the form of increased labor productivity. Selected studies suggest that health care can, in fact, play an important role in such a scenario.

Another avenue is the potential importance of health services in helping communities to attract and retain job-creating businesses and industries. For example, a company may meet strong employee resistance if it tries to transfer certain employees (e.g., a management team) into a community with sub-standard services. Scattered empirical evidence suggests such a relationship exists between infrastructure and the attraction of businesses and workers.

Apart from their role in attracting businesses and industries, health services may be even more important in attracting community residents. The concept of people as a rural economic base has become increasingly important with the growth in "passive income" (dividends, interest, rent, and transfer payments). Today, passive income accounts for one out of every three dollars in U.S. personal income, with much of this income tied to the retirement-aged population. This has come to be known as the "silver-haired" economic base.

Retirees, like business executives, may make their location decisions, in part, on the basis of the community health services. Any growth in an area in the silver-haired economic base leads to additional jobs, including additional health service jobs. For example, an Oklahoma study indicates that a full-time physician in a rural community typically employs 3.75 persons. The study also suggests that local spending generated by a physician's practice and the practice's personnel may generate an additional 13 nonmedical jobs in the local economy. Hence, the direct and indirect employment associated with an additional physician could conceivably involve nearly 18 jobs (including the physician). Similarly, it was estimated that a typical hospital in a rural Pennsylvania community of 7,700 population could account--directly and indirectly--for one-fourth of all the community's jobs.

The second major way in which health services can conceivably contribute to economic development and diversification is in their ability to export their services to a much wider geographic area. Spectacular examples of this approach include the Mayo Clinic in Rochester, Minnesota; the Geisinger Clinic in Danville, Pennsylvania; and the Marshfield Clinic in Marshfield, Wisconsin. Much smaller and more recent examples include drug and alcohol rehabilitation centers catering to the urban elite, but located in rural areas. Interestingly, 7 of the 40 industries that are projected to have the highest rates of job growth nationally through 1995 are health-oriented. Included among the seven are nursing and personal care facilities, physician and dentist offices, and hospitals.

Hospitals, as well as other health providers, also contribute to rural economic development by making investment funds available. For example, hospitals hold large sums of cash and other short-term assets in local, state, and regional financial institutions. These funds contribute to the pool of financial resources available for capital investment by area businesses and households.

CONCLUDING COMMENTS

Despite the important role health services can play in the larger scheme of rural development, I believe it is important that we not lose sight of the fundamental reason for having health services. This fundamental reason is to enhance the quality of life, including the reduction of pain, suffering, anxiety, and premature death. It is very distressing to me that some minimal level of health care is not guaranteed to all Americans, including our rural citizens.

In the case of our rural citizens, I am struck by what our founding fathers did 200 years ago. In Article 1, Section 8, of the U.S. Constitution, a commitment is made to provide postal services to all Americans; and rural Americans are a major beneficiary of that commitment. No matter how remote, and how isolated one's residence is, that individual will receive mail! Although this service may not include Federal Express, some minimal level of postal services are provided. The postal services example also illustrates a fundamental point: even minimal levels of some public services cannot be provided in many rural areas without an external subsidy. The ultimate question is whether or not our society believes some minimal level of rural health delivery, like rural postal delivery, is a basic entitlement for rural America and merits such a subsidy. To date, the answer is "no," and that is a disappointing situation. However, on the positive side, there are some favorable recent developments for rural health care.

First, during the past decade a strong and active grass-roots rural health movement has emerged. The focal point for most of the movement is the National Rural Health Association in Kansas City. The supporting includes rural organizations that have a health component (e.g., t Farm Bureau Association), and health organizations that have a rural component (e.g., the American Public Health Association).

At the government level, many states have developed strong and vibrant offices of rural health. Within the federal establishment, an Office of Rural Health has been established as part of the Department of Health and Human Services (DHHS). The DHHS also named very recently a National Advisory Council on Rural Health. I feel honored to have been named to this Council, and look forward to the challenges and opportunities that lie ahead.

At the Federal level, I see the need for two general policy considerations. First, policy for today's rural America must be keyed to two factors: the overall diversity that exists within rural America; and the common characteristic of instability and vulnerability at the local level. The first factor, when related to health services, suggests the obvious need to focus on a variety of very different rural health problems. For example, in the Western "frontier areas," the delivery issue is largely one of overcoming geographic distance and spatial isolation. On the other hand, in the rural South, the primary problem is often one of poverty. In this instance, the basic need is to provide financial assistance to families and individuals to pay for needed care. Researchers, along with policy makers, must be in-tune with such differences. Hopefully, the forthcoming establishment of Rural Health Research Centers by the DHHS will assist in giving us a better understanding of the rural health needs, and the policy implications associated with rural diversity.

The second factor is instability and vulnerability at the local level. The implications of this for health policy and health research are tremendous. For example, the instability of rural economies means economic disruption is commonplace, and the social fabric and networks of a community can be torn apart overnight. This suggests that mental health services should be at least as high a priority as medical services. As another example, the contribution of health services in diversifying and strengthening unstable rural economies should be of particular significance to policymakers.

Another aspect of the vulnerability issue has to do with instability in Federal policy; in addition to stable policies that persistently discriminate against rural areas. In the case of health care, the biggest issue may not be rural-specific programs and their funding levels, although these programs are of inestimable importance. However, sudden changes and discriminatory provisions in general health policy and related areas are also critical for rural areas. Two examples illustrate this point:

> 1. The main income assistance program for the poor, Aid to Families with Dependent Children, discriminates against rural areas. In many states, this program is limited to single-parent families. Because single-parent households are much more common in urban areas than in rural areas, a greater proportion of the rural poor are denied benefits. Furthermore, AFDC recipients are also automatically entitled to Medicaid. Hence, participation in Medicaid is also skewed away from the rural poor.
>
> 2. The definition of what constitutes a metropolitan area has significant economic implications. Having such a designation has been estimated to be worth $12 - $14 million annually in terms of eligibility for Federal programs, etc. In one borderline county, the metropolitan designation was estimated to be worth $1 million in Medicare revenue alone. The reason for this is the lower reimbursement rates paid to hospitals in nonmetropolitan areas in comparison to the metropolitan areas. It is my understanding that other witnesses today will explain the details of this untenable situation.

In concluding my remarks, I want to re-emphasize a single point: the problems and issues facing today's rural America are not even remotely related to yesterday's rural America. Whether we are particularly interested in rural health, rural education, or general rural development, each of us must avoid the same pitfall: the tendency to want to solve yesterday's problems.

Thank you.

The **Chairman**. Mr. Cordes, do you share the view, which some of us have already spoken to, that rural hospitals are indeed threatened?

Mr. **Cordes**. Most certainly. I would say—and who knows what the exact figures could turn out to be—that we are dealing with something of catastrophic proportions. I believe you could see literally hundreds of hospitals close in the next decade.

The **Chairman**. Thank you.

Senator Burdick, do you have any questions?

Senator **Burdick**. Welcome to the committee, doctor.

Mr. **Cordes**. Thank you.

Senator **Burdick**. In your testimony, you referred to the lack of programs to retrain farmers and other rural workers in order to augment their income. I share your concern and have a new pilot program I am working on to retrain some of these people in needed health occupations.

Do you have any other specific ideas how we can help this population?

Mr. **Cordes**. I think the general notion of investing in the human resource in rural areas is essential—and there are three important aspects of that. One is health care, one is nutrition, and one is education.

As you invest in those human resources and they become more productive, you do two things. Number one, you make those rural communities more attractive for businesses and industries because the labor productivity is higher. Secondly, even if the community does not survive, at least you provide the opportunity for those people to leave the area and compete effectively in the metropolitan areas.

Senator **Burdick**. Thank you.

The **Chairman**. Senator Grassley, do you have any questions?

Senator **Grassley**. I would just simply ask you to elaborate on something you raised in your testimony, and that is one of the assumptions of the prospective payment system; that the efficient hospitals will do well, the inefficient hospitals will not do well, and if you carry that to the extreme, eventually that means persistently inefficient hospitals are going to close.

We constantly hear that kind of talk here in policy circles in Washington, and I surely hear it in my State as I am sure you do in your State.

If these "inefficiencies" have nothing to do with good management versus bad management but everything to do with circumstances over which the hospital has no control, particularly if that hospital provides a very basic vital health service for the community and, even more importantly, if it is the only hospital within a reasonable distance, what is the extent to which we ought to have primary concern for keeping that hospital open regardless of its "inefficiencies?"

Mr. **Cordes**. I think this goes back to the notion of how we view health care. If you believe some minimal set of services should be made available to all rural residents, then there are going to be areas in the United States that will require some form of external subsidy. It is just not going to be possible otherwise, either because of low incomes or because there just aren't enough people there, even though they may be fairly high income people.

So, if the need for a subsidy is how you define inefficiency, then, yes, there will be some "inefficiency" in rural areas. However, at least you will provide that minimal set of services.

Furthermore, I am not particularly worried about the cost of such a subsidy. We are not talking about big bucks. If you are really interested in cost containment, you should be more concerned about the major hospitals and the technological advances, and how you get a handle on those kinds of things.

In fact, if it is true that the reason Medicare—and I say this somewhat with tongue in cheek—reimburses rural hospitals less is because it is less costly for rural hospitals to provide services, then it seems to me that we should be talking about closing urban hospitals and shifting the patients into rural hospitals where it is less costly.

Senator GRASSLEY. Well, I thank you for that answer. We have talked some about health care personnel, and I hope Senator Burdick wouldn't mind my mentioning that he and Senator Inouye are going to be lead Democrats to co-sponsor, and I am going to be the lead Republican co-sponsor, of a bill that we hope will attract more health care personnel to rural areas and keep them there. I think we will have this bill ready for introduction in the latter part of this month.

However, I suppose there are several ways we can approach this. Different people would have different ideas, but we have joined together in hoping that this would encourage health care professionals to try the rural experience and hopefully like it and stay there.

The CHAIRMAN. Thank you, Senator Grassley.

Senator Shelby, do you have any questions?

Senator SHELBY. Thank you, Mr. Chairman. I have an observation and a question.

About the differential between urban hospitals and rural hospitals as far as Medicare reimbursement is concerned, it looks to me like that is a fundamental problem that we have, because if Medicare is not willing to pay the costs—I call it a bias—between urban and rural hospitals—and all of us up here have been through some of this probably to upgrade a hospital that has grown in an area from a rural reimbursement situation to an urban, and it has been hard for me to explain in my State of Alabama to smaller town people why the differential is there in the first place.

Now, my question is, if we abolish the differential, do you have any figures on what that would cost to do this? I don't know if it is politically practical to do—and would that solve some of the problems? Do you have any observations on that, Doctor?

Mr. CORDES. I do not have an estimate of the cost of that. I would argue, though, that it would not be that large, because, again, even though we may be talking about a substantial number of hospitals, we are talking about a fairly small percentage of the total patient load nationally.

Your second question was whether or not eliminating the differential would help—most definitely. There is absolutely no question about that, because Medicare is such a large proportion of the total revenues received by hospitals, in general, and rural hospitals, in particular. Because of the high proportion of the elderly in rural areas, anytime you tinker one way or the other with Medicare, you are going to send tremendous shock waves through the rural hospital system.

Senator **SHELBY**. Could you for the record and for the Chairman and members of the committee and especially this Senator furnish that information if you can obtain it? I know you are a professor. Can you get some numbers there?

Mr. **CORDES**. I think that information does exist and could be put together. I would do my best to try to provide that.

Senator **SHELBY**. Thank you.

[Subsequent to the hearing, the following information was received:]

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June 30, 1988

The Honorable Richard C. Shelby
U. S. Senate
Washington, D.C. 20510

Dear Senator Shelby:

When I presented testimony to the Senate Special Committee on Aging, you asked the following question: "...if we abolish the [Medicare payment] differential, do you have any figures on what that would cost...?"

In order to answer that question, I contacted the Office of Rural Health. Jake Culp, in that office, subsequently contacted Dena Puskin in the Prospective Payment Assessment Commission (ProPac). The unofficial estimate from ProPac is $550-$700 million annually. If you need further details on how that figure was obtained, I suggest you contact Ms. Puskin.

I appreciated the opportunity to testify before the Committee. It was encouraging to see so many Senators, including yourself, expressing so much concern and interest in the very real problems facing the rural health care system.

I hope I can be of service again in the future.

Sincerely yours,

Sam Cordes

Sam Cordes
Professor and Head

SMC:ckk

cc: Jeff Human
Jake Culp
Chris Jennings
Dena Puskin

Senator **Shelby**. Another observation you made earlier—and I thought it was basically true—the different situations facing hospitals in rural areas of the Northwest and West that is, States like the Chairman's State of Montana, Wyoming or others, perhaps New Mexico where distance and travel costs are serious concerns as opposed to my State of Alabama where poverty is a major problem. That is a good observation, and it is true.

Thank you, Mr. Chairman.

The **Chairman**. Thank you, Senator Shelby.

Senator Domenici, do you have any questions?

Senator **Domenici**. Just two or three very quickly.

Doctor, you mentioned the concern that you have about the fact that a substantial portion of the economic base of rural America is essentially tied to senior citizens because of the growing kind of income that you describe. Do you know of any evidence that there is a movement away from rural America as defined generically by senior citizens or is the movement in the opposite direction or rather neutral at this point?

Mr. **Cordes**. During the 1970's, a very unusual demographic event occurred, and that was the fact that rural America grew more rapidly than urban America. The elderly were over-represented in that flow from urban to rural areas which means that the elderly migration flow was, of course, also in that direction.

What has happened since then, since 1980, with the reversal of the urban to rural migration phenomenon is something I don't have data on. I don't know how the elderly are represented in the slow-down.

Senator **Domenici**. So, you are saying you don't know if the migration is out or not at this point.

Mr. **Cordes**. Yes. There is some of both, but I am not certain of the net effect.

Senator **Domenici**. I understand that we have specialists and you are more of an agricultural and rural generalist, but with reference to personnel, nurses and the like, we are all aware of the national shortage. It has even hit veterans' hospitals.

Might I ask, do you have any indication as to whether we are attracting sufficient young people to be trained as nurses? It would be my guess that we are not, that the number of young men and women in the schools attempting to become nurses is down now rather than up and the need is up. Is that a fair assessment and, if so, what is the principal reason in your opinion?

In mine, it is pay. I believe the nursing profession is underpaid, and in our country, most generally, young people choose professions that they like, but, essentially, they don't choose professions that they don't think they can make a living at.

Would you address that briefly?

Mr. **Cordes**. Well, I will address it very briefly, by simply noting that I agree with your analysis.

Senator **Domenici**. My last point is, I sensed an inconsistency in your myths, but I am sure there wasn't. You indicated rural America is diverse, but then you said, nonetheless, they are more adversely affected because they are kind of specialized economies.

Did you mean in your first remark that in the aggregate they are diverse but with regard to specific locations they are not, and is that the case?

Mr. CORDES. Exactly. If you aggregate all of rural America and compare it to all of urban America, you will be struck by the similarities. But if you look at any particular rural area, it will be a specialized economy.

So, what you have is a series of specialized economies throughout rural America. If you throw them all together, it gives you a picture that is roughly similar to urban America. However, when you disaggregate and you have to deal with each of those as a specialized rural economy, it makes that economy very vulnerable.

Historically, we viewed rural America as being isolated and insulated and out of the main stream and so on. My argument is that it is exactly the opposite today. It is precisely because rural America is so interdependent with international monetary forces and everything else imaginable, Medicare reimbursement changes and so on, that causes the problem. Twenty years ago, it was the opposite problem of isolation.

Senator DOMENICI. Thank you, Mr. Chairman.

Thank you, Doctor.

The CHAIRMAN. Thank you, Senator Domenici.

Senator Breaux, do you have any questions or comments?

Senator BREAUX. Thank you, Mr. Chairman.

Doctor, let me just play devil's advocate for a moment with regard to your analogy with regard to rural citizens who get and have a right to postal services, the delivery of mail to rural areas, and everybody gets the mail, the point being that every small town doesn't have a post office. The post office has shown that they can get better delivery or at least equal delivery services to a rural area by not having a post office located in that little community but having cars and trucks from a central location bring the mail and provide the services.

Some would argue that the same analogy should be used with rural hospitals, that we shouldn't be arguing about whether every community has a rural hospital but whether they have quality health care, and some would argue that a town that is 25 miles from a large city or even 50 miles from a large city can get more than adequate quality care because of transportation today being what it is—helicopters, ambulance services, motorized vehicles—and that it is a mistake to try to insist that every little community have a rural hospital when they are located within an urbanized area and that we can give them the same quality health care.

What are your comments on that?

Mr. CORDES. The notion that some rural hospitals are closing would not be of particular concern, apart from the larger rural development issue; if there was a fundamental commitment to provide something in their stead. However, I am not convinced that that is going to happen.

In the case of postal services, the commitment is there. The ultimate product does get delivered. It may get delivered different ways in different sized communities, but the job gets done.

There are a number of different ways of providing services and with changes in transportation and so on those ways can change over time and from area to area. This is an important aspect of the whole scenario. I think some of the other witnesses are going to provide some testimony on some innovative ways of providing health care, but my concern simply is that the ultimate commitment and the ultimate product will not be delivered in the same way that we have with postal services.

Senator **Breaux**. Would you make an argument, then, that a rural community cannot have the same adequate health care as an urbanized area, say, if they are located within 25 or 50 miles of an urban facility without having a rural hospital located in that community?

Mr. **Cordes**. I like to think in terms of some minimal set of services that we as a society would define as adequate or acceptable, and should be available to everyone regardless of place of residence, race, et cetera. I don't know exactly what the specifics are of that minimal set of services. Also, there is no doubt that that minimal set could be provided, in some cases, without the existence of a hospital.

I am concerned that that minimal set of services, however we might define that, is not currently available and may be further from our reach with the current Medicare reimbursement situation.

Senator **Breaux**. Thank you.

Thank you, Mr. Chairman.

The **Chairman**. Thank you, Senator Breaux.

Senator Pressler, do you have any questions or comments?

STATEMENT BY SENATOR LARRY PRESSLER

Senator **Pressler**. Thank you, Mr. Chairman, for holding this hearing. I think the fact that nine Senators are here this morning indicates the importance of rural healthcare.

When I go into small towns and rural areas in South Dakota, quality of life is a key issue. Medical care and the delivery of health services become important to those individuals living in rural areas. If someone has an accident or has a medical problem, they want to be able to get immediate assistance.

Earlier, I listened to your response to Senator Domenici's question on nurses. I am very concerned about the nursing shortage. I have two sisters who are registered nurses, and I know first hand some of the concerns nurses have with inadequate pay and working conditions. Let me ask you several questions regarding physicians in small towns and rural areas.

We have tried at the University of South Dakota to have an incentive program to get more physicians to relocate to rural areas. It has worked to some extent, but it is not working as well as we had hoped.

I don't know if it is a matter of pay or quality of life that would attract physicians to rural areas. What specific recommendations would you have to keep physicians in rural areas?

Mr. **Cordes**. I believe some of the programs that have been put in place that are currently being threatened like the National Health Service Corps are the kinds of programs that you will have to have. Again, there are some communities, whether the concern is with hospitals, physicians, or whatever, that simply cannot provide these services on their own. The resources just aren't there.

In those cases, you are going to have to have some kind of external subsidy. Now that can come in the form of something like the National Health Service Corps. It can come in the form of Federal ownership of the system as it does in the case of Indian Health Services, but somehow there has to be that kind of an approach for at least certain areas.

The question was raised earlier about efficiency and inefficiency. I think one of the most inefficient ways of dealing with the doctor issue is what we are currently doing. During the last two decades we expanded the total pipeline of physicians in hopes that about 1 out of every 10 would go into rural areas. If you want to talk about inefficiency, I find the notion of cranking out hundreds of thousands of doctors so that 10 percent of them will go into rural areas to be ludicrous.

Senator PRESSLER. So, your recommendation is to have some form of a subsidy to keep physicians, at least from a financial point of view, in these smaller towns.

Mr. CORDES. I think the primary criterion is income, but there is more to it than that. For example, professional isolation is a problem. I think there are ways of dealing with professional isolation. We deal with that to some extent through the area health education centers.

I think the financial issue is the one that is most crucial.

Senator PRESSLER. Thank you very much.

[The prepared statement of Senator Pressler follows:]

STATEMENT BY SENATOR LARRY PRESSLER
BEFORE THE
SENATE SPECIAL COMMITTEE ON AGING

HEARING ON
RURAL HEALTH CARE

Mr. Pressler: Mr. Chairman, as a member of the Senate Rural Health Caucus, I commend you and your staff for organizing this hearing. Today, the Senate Aging Committee has recognized the important role played by rural hospitals in the delivery of health care to our nation's elderly. One quarter of our population and one third of the elderly live in rural communities. These older Americans, afflicted with multiple chronic conditions, rely more heavily on rural hospitals than does the general population.

Rural hospitals are the cornerstone of rural health care delivery systems. In addition to providing basic acute care, these facilities often provide home health services, respite care, nursing home care, preventive health care, and other services.

I am very concerned about the stability of our rural health care system. A weakened economy, resulting from foreclosures on farm mortgages, low farm commodity prices and bank closings threaten the economic health of rural hospitals and their surrounding communities. The unemployed worker and rural elderly often lack health insurance sufficient to pay for hospital care. Due to an eroding tax base, local governments may be too financially stretched to subsidize rural public hospitals.

As utilization of in-patient services continues to decline across the nation, urban hospitals expand into rural areas in an attempt to fill their empty beds. Too often technology does not reach rural hospitals. Small rural hospitals cannot compete with large urban hospitals in offering the latest equipment and technology to attract patients.

While Prospective Payment System payments make up a higher proportion of rural hospitals' total revenues, urban hospitals receive Medicare payments averaging 37 percent higher than rural hospitals. This difference helps explain why most urban hospitals make money on Medicare while most rural hospitals cannot even recover their costs.

Separate urban and rural PPS rates can be justified for only urban hospitals if they treat more severely ill patients. Health care researchers have not found a systematic difference in the severity of illness of urban patients or in-patient outcomes between urban and rural hospitals.

I have touched on several factors which make it difficult for rural hospitals to meet their fixed cost and operating expenses. In order to survive, many rural hospitals have to cut back. For example, Huron Regional Medical Center, located in Huron, South Dakota, has had to reduce its staffing in order to maintain its economic solvency. Other hospitals are choosing different strategies to survive--diversification, forming alliances with other providers, joining multi-hospital systems, or converting acute care beds to nursing home "swing beds."

Many rural hospitals are not so lucky. Since 1980, 161 rural community hospitals across the nation have closed, including one 20 bed facility in my State of South Dakota.. Of the remaining 2,700 rural hospitals, as many as 600 are at risk of closure. Ipswich Community Hospital, located in Impswich, South Dakota may close at the end of the month because it can not recruit a physician. Mr. Chairman, the rural communities need their hospitals. We must not let the rural hospital become an institution of the past.

The **Chairman**. Senator Reid.

Senator **Reid**. Thank you, Mr. Chairman.

I stepped out for a minute to meet someone from Nevada, and as I was standing there, Senator Simpson walked by. I told him a truth. I have been very impressed with your testimony, and Senator Simpson from Wyoming should be glad that there are people from Wyoming that are able to enlighten this committee as much as you have.

So, I appreciate the testimony that you have given.

Mr. Chairman, the main question I have—I just asked my staff—does the Aging Committee staff has his curriculum vitae? I would be interested in looking at that. Do we have that available someplace?

The **Chairman**. Yes, we do.

Senator **Reid**. Okay. I have no questions.

The **Chairman**. Thank you, Senator Reid.

Senator Simpson.

STATEMENT BY SENATOR ALAN SIMPSON

Senator **Simpson**. Mr. Chairman, I want to thank you very much for having this hearing, organizing and holding it, and I have enjoyed working with you.

Some of the things that were frustrating to me when I came on the committee I shared with you in an honest expression of my concern, and you have been very helpful and cooperative in seeing that some of my thoughts were addressed, not necessarily in having Dr. Cordes here, although that is certainly a remarkable benefit, because he was recently appointed to the National Rural Health Advisory Committee, and I thank all of you and I thank Harry Reid. Thank you for that, Harry.

Dr. Cordes is an impressive man. We are very fortunate to have him at the University of Wyoming. He is the head of our Department of Agricultural Economics, but he got a B.A. degree from South Dakota State. I wanted you to know that, Larry!

Senator **Pressler**. I knew there was something good.

Senator **Simpson**. Yes, it is something to be excited about.

And a Ph.D. from Washington State, so that covers that and then, of course, a professor at Penn State University, and we are very happy to have him at our university.

So, I think I will just enter my statement into the record, Mr. Chairman, and just say that we are now at this tough issue. We have to look so closely here at what we are doing. We have created problems for providers and those who need the services, and the rural communities have been especially hard hit.

This outlier problem is really one that just is tearing up some of these small hospitals where there are $60,000, $70,000, or $80,000 on a single case that is never ever recovered.

The statistics are rather startling, rural hospitals shutting down leaving 48 counties in America, rural counties, without hospitals, but those are the things that we are here to probe.

Of course, like everything we do in this arena, we spent billions to build the health care capital building system. The Hill-Burton Hospital Construction Act was the principal way everybody got into the game in the 1940's and 1950's. Like Jimmy Durante said, "everybody got into the act," and you were simply supposed to go build a hospital. The Hill-Burton money was there, and that was your duty—go get some of it.

We all did. We did it in my State. We did it in my county, and that fueled the expansion of the federally funded health care along with Medicare, and those things. We just want to ensure that everyone benefits from this huge system, and, of course, it comes with a price tag.

We are spending $550 billion this year alone on health care, and that is 12 percent of our entire GNP, and the government pays half of it. Medicare, alone will pay $80 billion this year for 33 million Americans. Those are remarkable costs.

Under Medicare Part A, it may be bankrupt after the first part of the century, only 12 years away unless we get our act together. Part B Medicare—that was where the beneficiary was supposed to pay 50 percent and the government was supposed to pay 50 percent, and we all remember that. Now, the beneficiary pays 25 percent and the taxpayers, the rest of us, pay the 75 percent. We tried to raise that 1 percent three years ago, and the mail room broke down.

We all remember that, it is something to be addressed, it is a problem. That is for all taxpayers. The elderly are paying the taxes, too, you know, in the United States. So, when we throw it back on the taxes of all of us, we throw it back on the elderly, as well.

And then this business of utilization is critical and over-utilization, the attitude that someone else is paying for it. So, then we, through many people on this committee, came up with a prospective health care system, in 1983. We need to slow the tremendous cost increases. That is what happens when you dip deep into the government's till, controls are never far behind. That is where we are now, tracking it down, seeing what we can do.

It is a very imperfect system. That is the way we legislate, because we are certainly not perfect. People expect that of us—perfection—but I flunked that test long ago.

Rural hospitals, as I say, are feeling the brunt of it. I appreciate very much your turning your attention to it. I look forward to hearing what these innovations will be.

We have to tailor these policy initiatives to the specific rural communities, and they are very vulnerable. When the OPEC market goes down, it leaves some of these rural economies in Oklahoma and Texas and Louisiana and Wyoming battered. Wyoming, indeed, frontier areas, isolated communities—we are very vulnerable to that.

So, I am just pleased to participate, and I intend to lend whatever efforts I can to address the issues, and I compliment Senator Dole and Senator Burdick, our co-chairs of the Senate Rural Health Caucus. Many of us here on this committee are members of that, and Senator Durenberger has taken a leading role on these issues in legislation, and there will be a lot more debate.

We need to work with that caucus. So, I look forward to working with you also, Mr. Chairman. It is a serious issue and it is going to be big, big bucks, but somewhere along the line, we are going to have to sit down to consolidation and cooperation.

We just can't have them flourishing around the United States as they are now, because they are not flourishing. They are dying, these hospitals, and it is our job to coordinate it.

I thank you very much, Mr. Chairman.

The **CHAIRMAN**. Thank you, Senator Simpson.

Just one comment, Mr. Cordes, before you leave us. You have given an example that I think is very pertinent and one which this hearing must zero in on, and that is the discrimination against rural hospitals with respect to payments from Medicare. You mentioned one example where a hospital, experienced a $1 million difference from not being designated within a metropolitan area. This is precisely the problem this hearing wants to examine.

When we get to our last witness—Dr. Ross Anthony, the Associate Administrator for Program Development of the Health Care Financing Administration—we will ask him for an explanation.

Thank you very much for your very well-rounded testimony.

Mr. **CORDES**. Thank you.

The **CHAIRMAN**. I now yield to Senator Breaux to introduce the next witness.

Senator **BREAUX**. Thank you, Mr. Chairman.

I mentioned Mr. Cooper, and if you will just come on up to the witness table, we will go ahead and begin.

Mr. Cooper is from Louisiana. He is an administrator of two hospitals, one a 75-bed hospital and the other a 43-bed hospital. He is President of the Northeast Louisiana District of Hospitals which represents 20 hospitals. Of those 20, I think about 15 are classified as rural.

So, we are very pleased to have him. He brings with him a history of involvement in rural America and rural hospitals, and we are very delighted to have him up here with us today.

The **CHAIRMAN**. Please proceed, Mr. Cooper.

STATEMENT OF MICHAEL COOPER, ADMINISTRATOR, RICHLAND PARISH HOSPITALS, RAYVILLE, LA, ACCOMPANIED BY JOHN JUROVICH, VICE PRESIDENT, LOUISIANA HOSPITAL ASSOCIATION

Mr. **COOPER**. Thank you, Mr. Chairman and members of the committee.

I am Michael Cooper, Administrator of Richland Parish Hospitals in Delhi and Rayville, Louisiana. As Senator Breaux pointed out, currently, I serve as the president of the Northeast District of the Louisiana Hospital Association. I also am a registered pharmacists in the State of Louisiana, and I am a licensed nursing home administrator.

With me today is Mr. John Jurovich. Mr. Jurovich is the Vice President of Finance for the Louisiana Hospital Association. Towards the end of my testimony if there are any questions of a technical nature, Mr. Jurovich may have to help me out with those.

I would like to thank you today for inviting me here to testify before the committee. Senator Melcher and, in particular, Jenny

McCarthy has been a tremendous help in getting me straightened out and on the right track here, so I would like to thank Jenny.

We have many challenges in the rural areas that we are facing, and I would like to primarily address three of those challenges and then, at the end, tell you some of the things that we are doing to try to cope with those issues that are adversely affecting us.

The first issue is inadequate reimbursement. In our particular hospital system, we border a metropolitan hospital area where we find ourselves competing for the same professionals as that metropolitan area. In other words, we have to pay the same salaries, the same wages, the same fringe benefits, or with our lovely interstate hospital system, we will find these young mobile professionals going to those metropolitan areas.

While we have to pay these people the same amount of money in salaries and benefits, we find that the urban areas receive 20 to 40 percent more reimbursement for the same procedures that we perform at our hospitals.

Since 1982, in order to cope with these issues, we have seen a real 5.2 percent decrease in salaries in our Richland Parish Hospital system. During that same period of time, however, we have seen a 21 percent increase in salaries for those professional people such as nurses, physical therapists, respiratory therapists, et cetera.

The administrator sitting in front of you has not had a pay increase in four years, so I don't fall into that 21 percent increase.

What has happened, then, with that 5 percent decrease for nonprofessionals means that we have had about a $.5 million loss in payroll, a $.5 million impact on our little rural community in Richland Parish, and that is significant. 65 percent of our clients, our customers, our patients are Medicare patients.

According to Dr. Christopher Johnson who is the director of the Northeast Louisiana University Gerontology Association, we have in Richland Parish 20 percent of our entire population that is considered elderly. Tragically, of that 20 percent, 43 percent fall at or below the poverty guidelines.

With the introduction of PPS and its sword of Damocles, the PRO, we have seen the average length of stay in our hospitals, to exemplify this, in the Delhi Hospital, the average length of stay has increased from 5.5 days in 1985 to 7.5 days in 1987. This indicates a more intense utilization of services to Medicare recipients as our total increased length of stay has been only 10 percent.

The Medicare contract adjustments—I will briefly explain that to you as the difference between what our hospital charges are and what Medicare pays us—one year ago, the fiscal year ending 1986 were $1.2 million for our small hospital. In 1987, that figure rose to $2.4 million for a 90.63 percent increase.

Now, you may be saying well, that is probably because we are charging too much money. Not according to Blue Cross of Louisiana who, when they came to our hospital to ask us to join a preferred provider arrangement, offered us a zero percent discount because our charges for hospitals of our size were at or below the median level.

We feel that another issue that we face is the fact that we have virtually no industry in our rural part of the country, therefore, no third party payers to pass our losses on to. The majority of our area depends upon agriculture and oil. For the past seven years, we have had a depressed agricultural economy, and for the past two years, the oil industry has been very depressed in our particular part of the country.

So, we don't have anybody to pass, if you will, these "bad debts" on to.

Rural families in our area, anyway, do on the average less well than those people in the urban areas. In Richland Parish, the average median income for a family is $15,297. In Ouachita Parish which is 10 miles away from us with the metropolitan Monroe area about 25 miles away, the median family income is $27,442 or 30 percent more.

Thirty percent of the families in rural Richland Parish live at or below the poverty guidelines. Unemployment in our area averages 18 percent.

Another concern is that we are experiencing increased deterioration of assets. In 1985, our assets were $9.3 million. As of the middle of this year, our assets are $8.1 million, or a decrease of $1.2 million in roughly a two-year period of time. This is primarily due to the lack of being able to replace certain essential pieces of equipment and repairs and additions to buildings that are needed.

Another area of concern is utilization. Many of the factors that we have discussed here today and that I have just discussed go into play here.

In 1982, Louisiana had a total of 80 rural hospitals which averaged 61 percent of occupancy. Today, there are 74 such hospitals that average 44 percent occupancy.

In our Rayville-Delhi system, there were a total of 5,051 admissions to our hospitals in 1985. We have seen that drop to 3,441 in 1987. Medicare admissions in 1986 were 2,221. Last year, they dropped to 1,774.

Much of this is due to the fact that the PRO, the Peer Review Organization, the group that has been mandated to overlook physicians from, in our case, 200 miles away, has made many of these patients have to have their services on an out-patient basis which is double.

I would like to point out here that in the rural areas in particular, we find that reimbursement is at an unacceptable level for our out-patient utilization. HCFA itself has asked for a 17.5 percent increase in ambulatory surgery procedures while OMB has asked for a zero percent.

We find that many of the other aspects of health care that we have to do such as home health, et cetera, is seriously compromised by either increased regulations or low reimbursement.

What are we doing in our area as to help alleviate this problem? First of all, new thinking, sweeping changes are occurring in the rural areas. We are finding ourselves having to look at marketing strategies to compete with the urban areas.

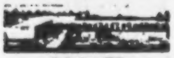
We are providing nursing scholarships from beginning to end. In 1982, we began a group purchasing arrangement. In 1983, we entered into the home health business which now encompasses 50 miles of our parish. We have joint ventured with other hospitals and doctors and doctors on such issues as quality assurance, biomedical techs, and surgery. We have built an out-patient clinic in our Mangham community and many other things that we have gotten into, but these things have not been enough to help.

We have seen reduction in full-time equivalents from 320 to 232. We feel that any further reductions will compromise quality in our area.

So, in closing, I would say that it is essential that rural hospitals be allowed to provide this care that is much needed by that person who cannot afford to travel to the urban areas, that person who is too ill to travel to the urban areas, and that person who wishes to be taken care of in his home town, the senior citizen.

Thank you.

[The prepared statement of Mr. Cooper follows:]



Richland Parish Hospitals

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507 Cincinnati
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STATEMENT OF MICHAEL E. COOPER
BEFORE THE
UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING
ON
THE RURAL HEALTH CARE CHALLENGE: PART 1
RURAL HOSPITALS

JUNE 13, 1988

Mr. Chairman, I am Michael Cooper, Administrator of Richland Parish Hospitals located in Rayville and Delhi, Louisiana. I am currently the president of the Northeast District of the Louisiana Hospital Association, an organization which represents twenty hospitals, fifteen of which are considered rural. I am a Registered Pharmacist and a Licensed Nursing Home Administrator, who has been in involved in the provision of rural health care for over sixteen years, with ten of those as the Chief Executive Officer of a small rural hospital.

I appreciate this opportunity to appear before you today to address some of the challenges being faced by myself and my associates in the rural hospital health care delivery industry. Major concerns include inadequate reimbursement for rural hospitals, utilization, and increased costs, as it pertain to increased pressures on the elderly who need health care.

Inadequate Reimbursement:

Rural hospitals in todays environment must compete with urban areas for health care professionals, i.e. nurses, x-ray technicians, surgery scrub technicians, physical therapists, and respiratory therapists; yet, rural hospitals are reimbursed at a minimum of 20 percent less than their urban counterparts. During the period between 1986 and today, our hospital system has seen a real decrease in overall wages of 5.2%. However, due to competition, new licensure requirements, and the shortage of certain specialities, the average professional employee received a 21% increase during this same period. The 5% reduction was due to the layoff of non-professional employees who find it difficult to obtain employment in the area, thereby increasing the unemployment and welfare cost to the parish and state. The $200,000 in savings to the hospital in payroll cost can be equated to a $450,000 economic loss impact on the parish annually.

In our particular hospital system, Medicare admissions account for over 65 percent of total admissions. According to Dr. Christopher Johnson of Northeast Louisiana University's Institute of Gerontology, of Richland Parish's 24,000 people 20% are considered elderly, with 42.3% living at or below the poverty level. This puts stress on rural hospitals in several ways:

1. Medicare patients, on the average, require more intense medical care. This is due to the advent of prospective pricing and peer review which limits inpatient hospital care to only those patients requiring acute care services. In the past due to a serious shortage of alternative delivery sites the rural hospital's patient mix included non-acute care delivery. With today's PPS environment, the patient mix has been concentrated into one that is acutely ill in all cases. As an example, the Richland Parish Hospital in Delhi has seen an increase in average length of stay (ALOS) for Medicare patients of from 5.5 days to 7.5 days, an increase of 36.4%. During this period in time, the total ALOS for the Delhi Hospital only increased 10.63% for all categories demonstrating the need for more care and utilization of resources for the Medicare patients. (Exhibit 1) This has resulted in a higher cost in treatment and consumption of resources by the hospital. For instance, Medicare contractual allowances (the difference between what the hospital bills and what it is paid by government entities) have increased over the past two years in our two hospitals from $1,259,000 to $2,400,000, a 90.63% increase.

2. Rural areas, in general, have fewer patients who are paying billed charges as there are fewer industries who can afford to provide insurance for their employees. Rayville and Delhi's major industries, farming and oil have been depressed for several years leaving very few who can afford to purchase insurance. In addition, Medicare and Medicaid write offs, (Exhibit 2) as well as general bad debts, have caused many insurance carriers to demand rates at less than billed charges. In addition, many rural areas find, that like Richland Parish, many of the people living there are, in general less well to do than those living in local urban areas. For example, Richland Parish has a median household income of $15,297, which is substantially less than the state level of $27,442, with nearly 30 percent of all families living at or below the poverty level. This is reflected in the high level of general bad debts exhibited by the hospitals in 1987, which was in excess of 1.5 million dollars (exclusive of Medicare/Medicaid bad debt and Hill-Burton obligation).

In 1987, our two hospital system had Medicare/Medicaid contractual allowances totaling nearly 2.4 million dollars. Generally speaking, this is a bad debt that in any other business must be passed on to other customers. Rural hospitals do not have the ability, unlike their urban counterparts, to pass these losses on to full billed charge payors. (Exhibit 3 and 4)

3. Over the past two fiscal years, and the first one-half of 1988, our hospital system, not unlike the other small rural hospitals around us, have seen an increased deterioration of assets and cash on hand decreasing from total assets in 1985 of 9.3 million dollars to, as of April 1988 assets of 8.1 million dollars or a decrease of 1.2 million dollars.

In summary, I am concerned about:

(1) inadequate payment to rural hospitals for the provision of care to the elderly and the indigent comparable to those same services provided in an urban setting.

(2) increased labor costs to rural hospitals providing quality care as a result of competition between urban and rural hospitals and new health care providers for a limited number of professionals.

(3) the inability of the small rural hospital to cost shift, governmental payment shortages to the private sector.

(4) deteriorating assets that will eventually place the small rural hospital in a difficult position to compete in the market place, replace buildings and equipment, or to add much needed new technology.

Utilization:

Many of the factors mentioned previously in this testimony have had tremendous impact on the ability of patients to make use of hospitals. In 1982, in the State of Louisiana there were 80 rural hospitals comprising 5,275 beds. These hospitals averaged 66 beds, with an average length of stay of 5.4 days and averaged 61 percent occupancy. By 1987, there were 74 such hospitals comprising 4,891 beds. The hospitals now average 74 beds each, with an average length of stay of 5.5 day and are 44% occupied.

The Richland Parish Hospitals Rayville - Delhi exhibited a reduction in total admissions from a high of 5,051 admissions in 1985 to a low of 3,441 admissions in 1987, a reduction of 31.87 percent. (Exhibit 5)

Occupancy per licensed bed in the Rayville facility, until 1987, has somewhat gone against the national trend of decreased utilization. (Exhibit 6) Occupancy in the Delhi facility, however, is almost a "text-book" example of small hospital utilization. (Exhibit 7) While our facilities have suffered a decrease in admissions and occupancy rates, it does not appear that they are as bad as many of the rural hospitals in Louisiana.

Medicare admissions fell in both hospitals from a high in 1986 of 2,221 to a low in 1987 of 1,774. (Exhibit 8 & 9) This corresponds with an increased utilization of outpatient services during this same period which is illustrated by outpatient surgical procedures increasing from an average of 20% outpatient in 1984 to in excess of 50% of all surgeries performed in 1987. (Exhibit 10&11) Outpatient Medicare reimbursement for ambulatory surgical procedures has not been adjusted since HCFA implemented rules in 1982 by any significant amount what so ever, and current proposed rules in which HCFA proposes a 17.5% increase are being held in abeyance by OMB which is demanding a 0% increase. It should be noted that the 17.5% increase requested by HCFA is based upon a limited number of free standing ambulatory surgical center (ASCs) procedures whose intensity may be much less than that furnished in a hospital outpatient surgical setting with its emergency backup facilities. Medicare reimbursement for other non-acute care services has been eroded to the point that the provision of these services in the future is at a critical juncture. The development of alternative delivery systems, with the hospital as the focal point in an integrated health delivery system is essential.

In summary, I am concerned about the inability to place an elderly patient in an alternative setting that matches his medical needs. Medicare reimbursement for outpatient laboratory and radiology services, outpatient ambulatory surgical procedures and other outpatient services are at such levels as to place the future provision of these services, by the hospital, in jeopardy. Other alternative treatment sites i.e. Home Health and Hospice, due to reimbursement levels, peer review requirements, and onerous state licensure make the provision and availability of these services subject to question.

Increased Costs:

Regulations from federal, state, and professional agencies have increased the cost of doing business for hospitals both directly and indirectly. The license fee for hospitals in Louisiana has recently doubled. Federal, state, and professional requirements as they pertain to infection control, discharge planning, OSHA requirements, State Fire Marshall requirements, hazardous waste disposal, peer review, and other compliance costs, have increased steadily over the past few years. The increased emphasis on infection control and hazardous waste disposal will significantly drive up the cost of compliance in the very near future
In addition to the increased labor costs, especially professional services, rural hospitals are faced with other cost increases that are universal to all hospitals. These increases, for the most part fall outside the control of the hospital and range from the necessity of paying for garbage pickup, which was once provided by the municipalities or parishes free, to tremendous increases in utility and insurance expenses. As an example, malpractice insurance for the two hospitals in 1983 was $125,909 or $24.33 per admission while expenses for malpractice insurance in 1987 was $249,589 or $72.53 per admission. This represents an increase of 198% for malpractice insurance alone. Utility expenses during this period showed an increase of 72.5% from $120,113 in 1983 to $207,191 in spite of several federal energy audits and grants to decrease energy consumption.

Current trends by local governments to increase property and sales tax on not-for-profit institutions, as well as congress's own Unrelated Business Income Tax (UBIT) proposals have a significant impact on rural hospitals, which, for the most part are non-profit parish (county) facilities.

Solutions:

During the past five years, since the introduction of the Prospective Pricing System, all rural hospitals, in order to survive have made sweeping changes. Many of these changes were not necessarily of the hospital's design, but were caused, as is most evolution, out of a desire and necessity to survive. Five years ago, the thought of an advertising (marketing) program for a small rural hospital would have raised eye brows and brought laughs from a room of experienced administrators. Today, many of those "old guard" administrators are either no longer employed as such, have made the necessary changes, or are selling their services as consultants in the hospital business.

One of the first steps taken by our hospital system, in late 1982 was to join a large nationally recognized group purchasing arrangement which offered our two small hospitals the same power as larger hospitals. A hospital based Home Health Agency was established in 1983 that now reaches out more than 50 miles from the center of our parish and offers alternative care to many former hospital patients as well as many who otherwise qualify for care. The hospital system has joint ventured with other small hospitals on various projects such as Quality Assurance and Biomedical Engineering. In addition, a 4,100 square foot out-reach clinic was built in a small town in a remote area of the parish with approximately 1,500 residents with a full time doctor provided by the hospital to care for the residents, many of whom are elderly and find travel to town difficult and expensive. Late in 1986 the 43 bed Delhi facility applied for and was granted liscence to provide "Swing Bed" Skilled Nursing care to Medicare recipients. Low physician reimbursement and inadequate medical necessity guidelines for this aspect of health care has prevented this program from being more successful. Evidence exists to indicate that this service has helped meet the needs of the elderly, but additional federal support is necessary to achieve its full potential. Nursing homes are very reluctant to offer skilled nursing home services to the elderly.

Due to federal requirements that would not allow a hospital of greater than 49 beds to enter into the "Swing Bed" program, and because of the high cost of entering into a Distinct Part Skilled Nursing Facility the Rayville hospital was unable, until recently to participate in the "Swing Bed" program. It is hoped that improved physician reimbursement and medical necessity guidelines will make this program more tasteful to the physicians such that the hospitals can make significant improvements in the delivery of skilled care.

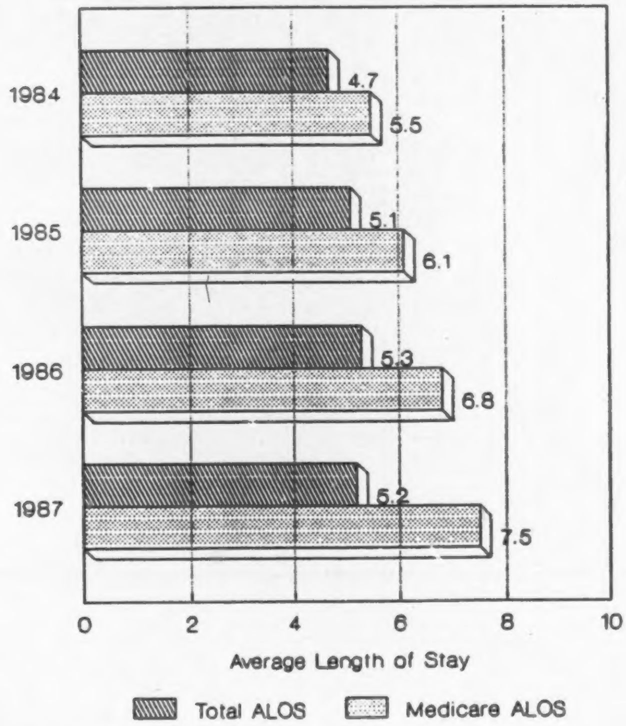
BUT, these new and exiting programs have not been sufficient to overcome the severe losses felt by most rural hospitals. We have sustained deep cuts in personnel going from 320 full time equivalents in 1982 to 232 full time equivalents in 1988. Reductions in "non-essential" personnel have come at a cost to our hospital system. Today we find most employees, including the administrator, no longer able to fill one roll, and in some cases find employees that must fill several job positions. We once considered one of our missions in our community, in addition to the provision of quality health care, the provision of sound long term jobs. Today, we concentrate on quality health care, and only the professionals are afforded the luxury of full time employment. While we have been fortunate, many hospitals are finding themselves allocating resources for the provision of stress related conditions for their employees. The termination of more personnel will in all liklihood lead to a decrease in the quality of care that we in the rural setting yearn to provide.

Rural hospitals are finding themselves having to access strategic cash reserves, i.e. funded depreciation accounts, etc., deferring the purchase of new technology, and/or delaying needed fixed equipment plant purchases to meet ongoing daily operation requirements. The long term results of such financing, if not offset by a return on and a return of equity will cause firstly a deterioration in the quality of care then the ultimate fiscal collapse of the hospital.

It is essential that rural hospitals be allowed to continue to survive, because the people who will suffer most without the rural community hospital is that person who can not afford to travel, that person who is too ill to travel, that person who wants to be taken care of in his or her community, the senior citizen.

EXHIBIT 1

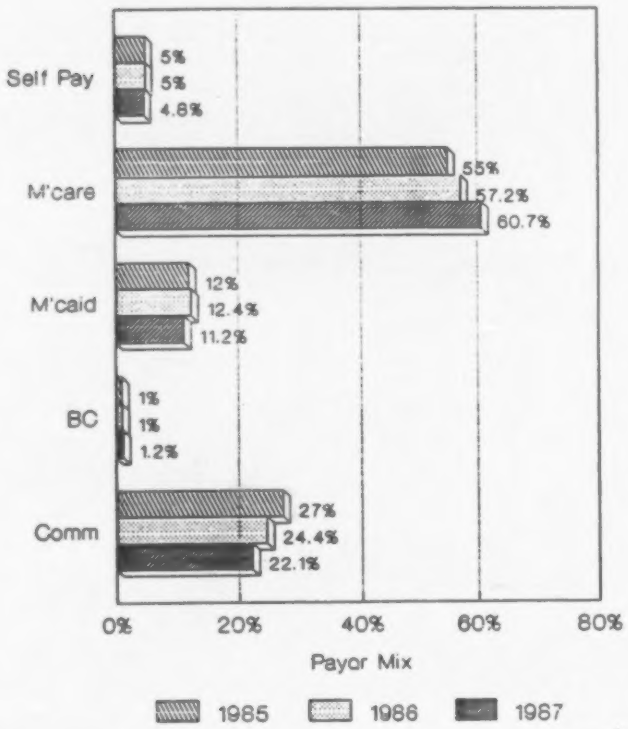
RICHLAND PARISH HOSPITAL - DELHI
HOSPITAL UTILIZATION



Hospital Records 1984 - 1987.

Professional
Marketing
Consultants, Inc.

EXHIBIT 2



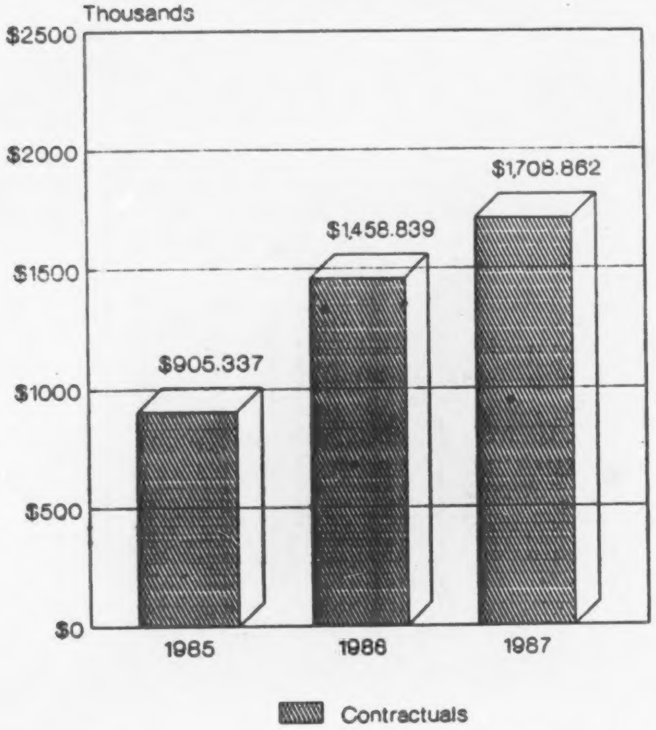
RICHLAND PARISH HOSPITAL - RAYVILLE
PAYOR MIX PROFILE

Hospital Records, 1985 - 1987.

Professional
Marketing
Consultants, Inc.

EXHIBIT 3

RICHLAND PARISH HOSPITAL - RAYVILLE
REVENUE ANALYSIS

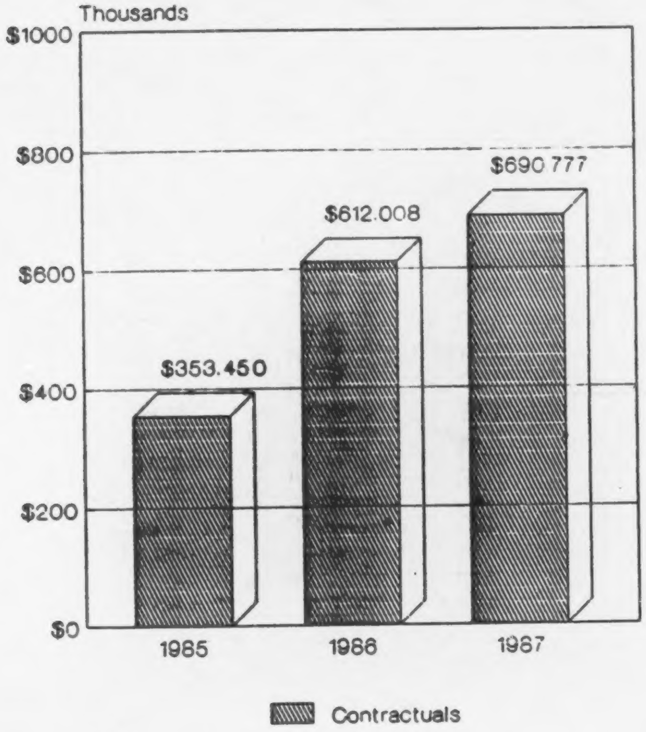


Hospital Records, 1985 - 1987.

Professional
Marketing
Consultants, Inc.

EXHIBIT 4

RICHLAND PARISH HOSPITAL - DELHI
REVENUE ANALYSIS

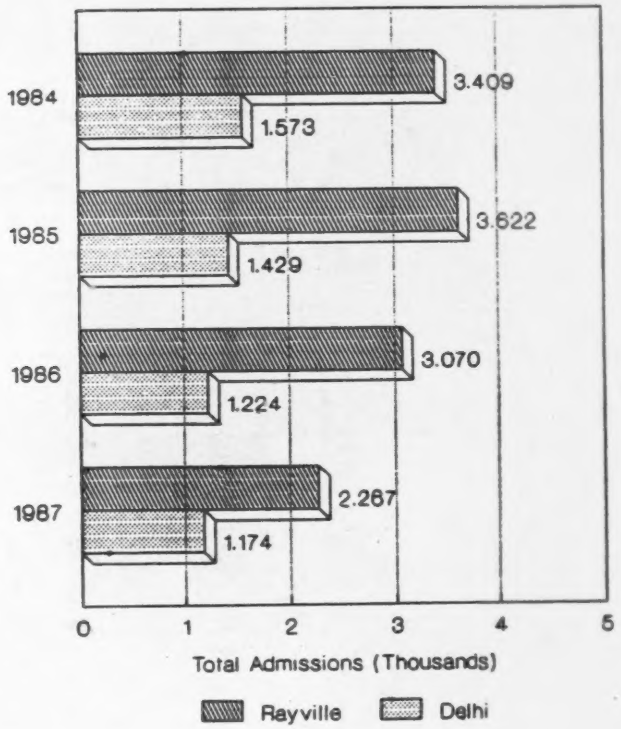


Hospital Records, 1985 - 1987.

Professional
Marketing
Consultants, Inc.

EXHIBIT 5

RICHLAND PARISH HOSPITALS
HOSPITAL UTILIZATION

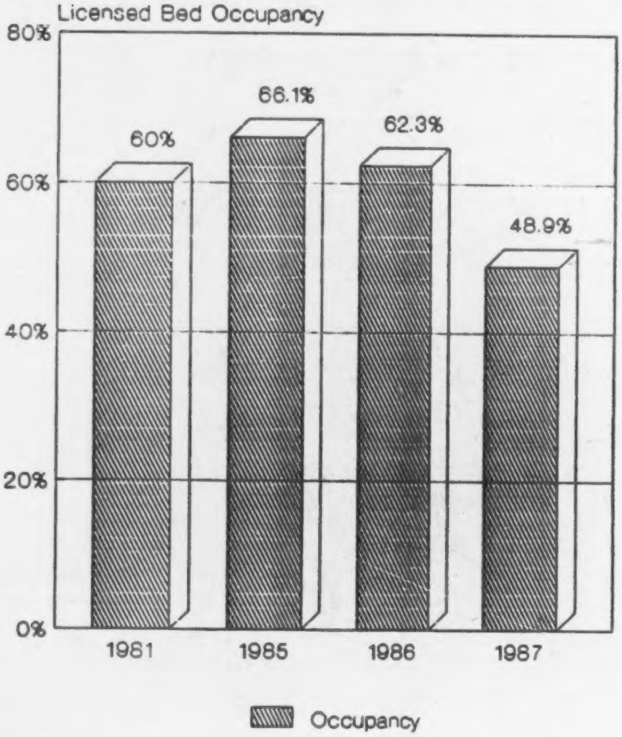


Hospital Records 1984 - 1987.

Professional
Marketing
Consultants, Inc.

EXHIBIT 6

RICHLAND PARISH HOSPITAL - RAYVILLE
HOSPITAL UTILIZATION

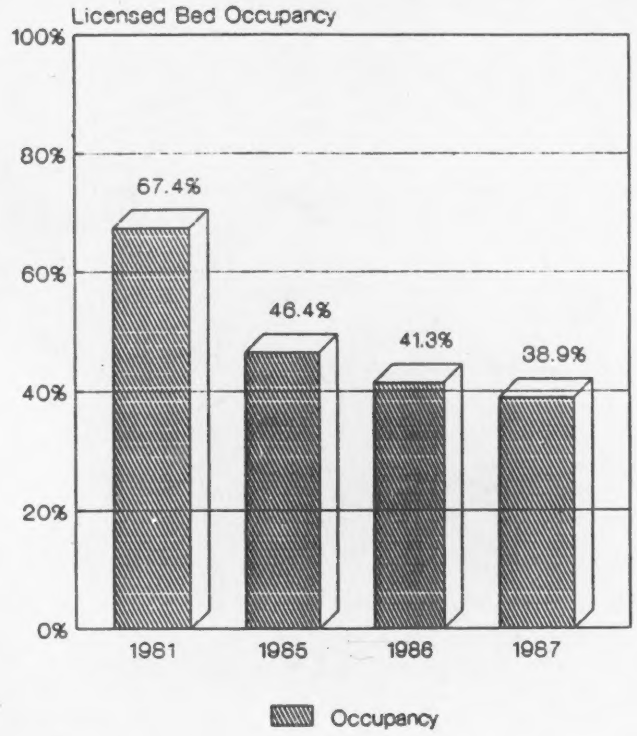


Hospital Records 85-87, AHA 80-82.

Professional
Marketing
Consultants, Inc.

EXHIBIT 7

RICHLAND PARISH HOSPITAL - DELHI
HOSPITAL UTILIZATION

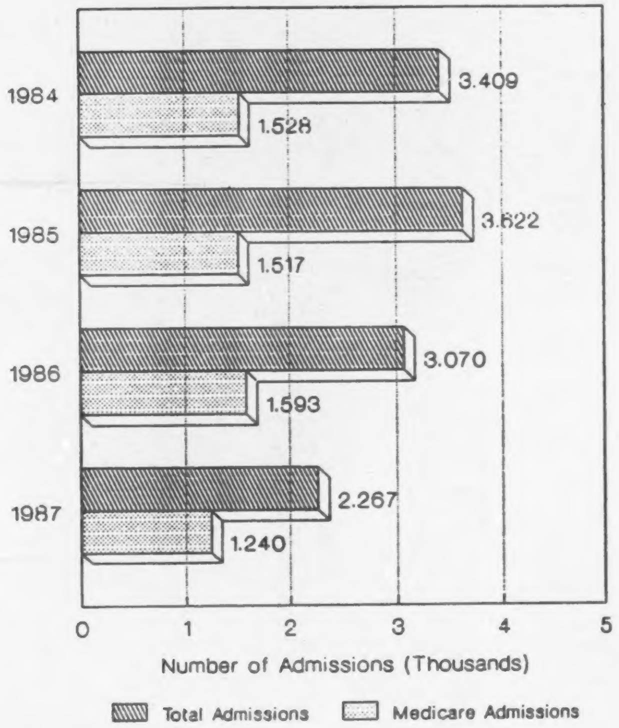


Hospital Records 85-87, AHA 80-82.

Professional
Marketing
Consultants, Inc.

EXHIBIT 8

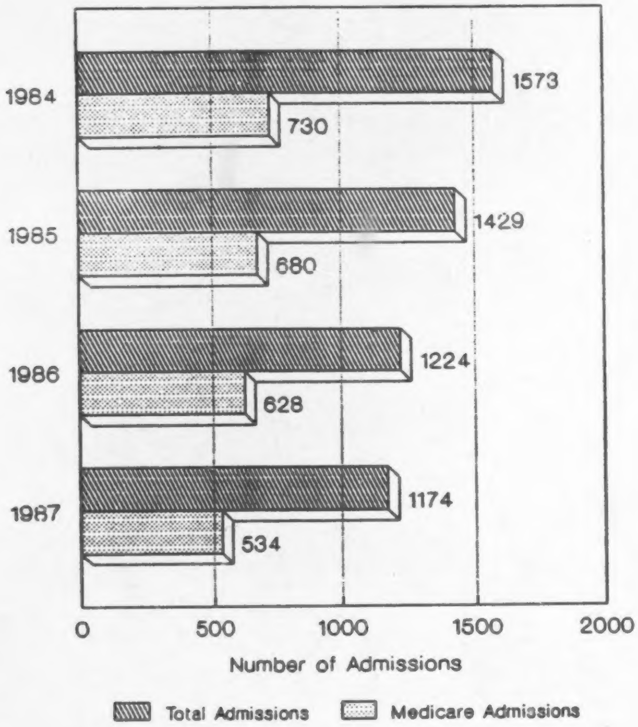
RICHLAND PARISH HOSPITAL - RAYVILLE
HOSPITAL UTILIZATION



Hospital Records 1984 - 1987.

EXHIBIT 9

RICHLAND PARISH HOSPITAL - DELHI
HOSPITAL UTILIZATION

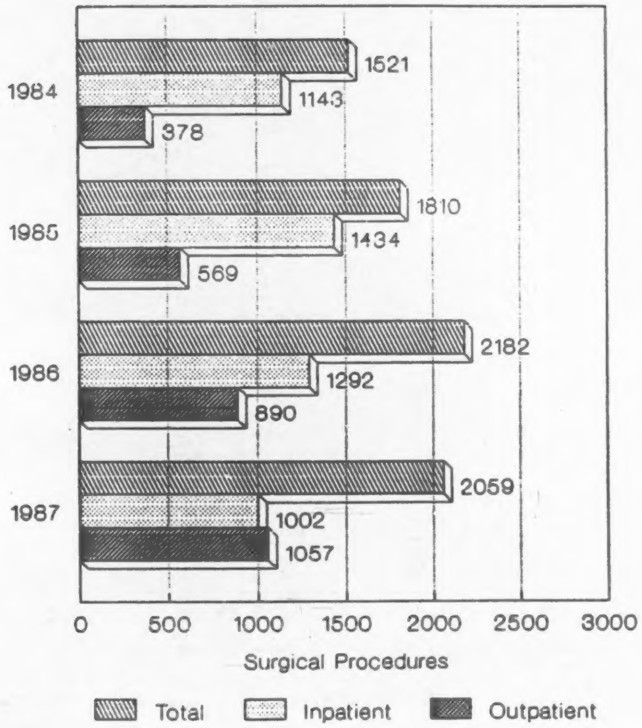


Hospital Records 1984 - 1987.

Professional
Marketing
Consultants, Inc.

EXHIBIT 10

RICHLAND PARISH HOSPITAL - RAYVILLE
HOSPITAL UTILIZATION

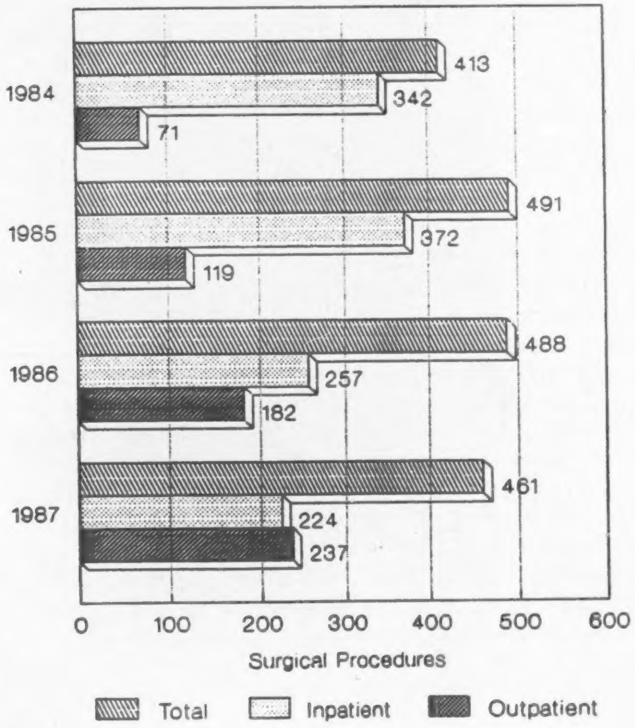


Hospital Records 1984 - 1987.

Professional
Marketing
Consultants, Inc.

EXHIBIT 21

RICHLAND PARISH HOSPITAL - DELHI
HOSPITAL UTILIZATION



Hospital Records 1984 - 1987.

Professional
Marketing
Consultants, Inc.

Senator **Burdick** (acting chairman). Thank you, Mr. Cooper.

In your testimony, you expressed concern about the availability of technology to rural hospitals. You may be interested to know that the Senate Rural Health Caucus has asked the Office of Technology Assessment to conduct a study on the aspects of health care in rural America. This study was recommended, in part, because of concern that we would see a widening gap between urban and rural technology based services.

The study will focus on identifying the ways developing technologies can be diffused into rural areas to improve access to and quality of care. I would be interested in knowing whether you have any other specific ideas on how to address the issue of technology in rural health care delivery.

Mr. **Cooper**. Senator Burdick, we have found that due to the deteriorating assets, we find it very difficult for us to go out and purchase some of this new technology. So, some of the things that we have done is to have the joint venture with doctors and other hospitals for provision of such things as computerized tomography, mammography, and other issues.

Senator **Burdick**. Senator Grassley?

Senator **Grassley**. Thank you, Mr. Chairman.

I want to ask a question similar to what Senator Shelby asked the previous witness, and that is about the rural-urban differential and how much difference—what the situation would be. He asked specifically if that had never existed, but I want to hit it just from a little different angle, and I want to refer specifically to the June of 1988 report of the Prospective Payment Review Commission.

In reviewing the effect on different groups of hospitals of recent Federal policy changes, this report of the commission states that "in the absence of other changes, the combined effect of the rural hospital provisions would remove the overall differential between PPS operating margins for urban and rural hospitals."

Now, the other changes that this statement alludes to are patient volume declines which have tended to offset the policy improvements. So, my question is, would you agree that recent policy changes have offset now the difference in payment between rural and urban hospitals?

Mr. **Cooper**. Senator Grassley, I would disagree with that. The most recent statistics that we have gotten from HCFA show a minimum of 20 percent differential in payment between urban and rural hospitals.

Senator **Grassley**. And you do know about the commission report that I just quoted?

Mr. **Cooper**. Yes.

Senator **Grassley**. I wonder if you could give us some about your experience with the hospitals with which you're familiar—or maybe that is just what you were stating.

Mr. **Cooper**. I think so, Senator. We still are experiencing a differential in payment between the urban and rural hospitals in Louisiana. Mr. Jurovich may want to expand on that.

Mr. **Jurovich**. Senator, we are having that differential still there, even though it is somewhat lessened with the new payment structure under the proposed rules of HCFA. However, the big problem, as I see it, is not only the rate of the differential but the fact that the utilization is so low in a rural facility. Even if you increase that differential considerably, when you only have 20 discharges a month, you are not talking that many dollars unless you add some other kinds of coverages in there or ease the burden of cost on those facilities.

Senator **Grassley**. Well, then, in sum, would it be fair for me to assume that you are saying even if we had maintained the same populations, say, the last 12 months as we had the 5 years before, even these policy changes we made, we still would not have made up the rural-urban differential the way that the commission implies that we would have?

Mr. **Jurovich**. Given the old volume of admissions and discharges, I don't think you would see the severity of the problem you are seeing today regarding the financial health of these hospitals. I think the report does make some valid comments, but I don't think it is totally correct.

Senator **Grassley**. Then, I should modify my question to say that if the populations had not gone down significantly, the policy changes Congress made would have eliminated the differential between urban and rural?

Mr. **Jurovich**. A very large portion of it, yes, Senator.

Mr. **Cooper**. If we could go back to 1985 levels, then we could live with PPS. We made profits in 1985 and 1986. 1987 and 1988 have been disastrous for us because of the PRO.

Senator **Grassley**. Now we have to look, then, beyond just the rural-urban differential for reimbursement. We have to look beyond that for some solution to the problems of rural hospitals.

Mr. **Cooper**. I think so.

Senator **Grassley**. On the other hand, we surely had to take what action we have taken, not only as a matter of fairness, but for the survival of hospitals to this point.

Mr. **Cooper**. Right.

Senator **Grassley**. Did you have another comment?

Mr. **Jurovich**. Senator, if you don't mind, as another alternative, if you are looking at something besides the differential, I would like you to look at the reimbursement rate for out-patient services which are growing by leaps and bounds in the rural facilities and which is their mainstay and really one of the major resources that hospitals can offer the rural community.

Current policy to reimburse for out-patient surgery is very insufficient to cover the cost of many cases and may keep the rural hospitals from participating or furnishing those services in the near future.

Senator **Grassley**. And from that standpoint, if we do want to encourage that as a public health policy to have people staying in the hospitals overnight less often than before, then it would be economically feasible for us as the Federal Government to encourage that sort of activity.

Mr. **Jurovich**. Yes, sir, and you would like to keep them out of the hospital and give them what they need whenever possible.

Senator **Grassley**. Yes. Mr. Chairman, that is all I have.

Senator **Burdick**. Senator Breaux.

Senator **Breaux**. Thank you, Mr. Chairman.

Mr. Cooper, thank you very much for a well documented statement. I know you have gone to a lot of work to present it, and the charts in the back, I think, are very helpful which indicate everything we need to know about a typical rural hospital as far as the mix is concerned.

One of the points I wanted to raise is you point out that we had 80 rural hospitals in Louisiana with 61 percent occupancy. Now, we have fewer hospitals, 74, and only 44 percent occupancy, dramatically down from what it was.

What is happening out there? Are we shifting to out-patient services? Are we shifting the patients to urbanized areas?

That is a dramatic trend, and it is pretty discouraging for rural hospitals if we now have fewer and we have a lot fewer people in a lot fewer hospitals. If that trend continues, we are going to see the inevitable occur if it continues downward. We are going to have no rural hospitals with no rural patients.

Mr. COOPER. Senator, we are like Doug Williams in the pocket. We are scrambling right now. We are trying to do a little bit of everything to make ends meet.

I know of one hospital in my district that has three separate taxes. It has a 6 mil tax on property, it has a half-cent sales tax, and another 54 mil tax for operations and for construction.

So, I think that you see the gauntlet being run.

Senator BREAUX. That is the problem we are facing, but what is causing it is that we have fewer patients. Now, we are not that much healthier than we were four years ago. So, my question really is, where have these patients gone?

Mr. COOPER. They are being treated, in large part, on an out-patient basis.

Senator BREAUX. Now, what is the argument as to why that is not a shift in the right direction?

Mr. COOPER. I think the argument that I can give you is that the physicians who treat these patients do not like having to treat these 85-year-old people, doing workups on them, and having to send them home, and, oftentimes, there is no one at home to take care of them. Young people have had to flee our area to try to find jobs, and they are not there to take care of their parents anymore.

In many cases, we find ourselves having to house these patients overnight knowing we are not going to get paid for them, but the doctor has insisted.

Senator BREAUX. What kind of change in the reimbursement system would we have to have in a rural hospital to make it comparable with an urbanized area? Would we have to eliminate the differential?

One of the points I made is you pointed out correctly, I know, that the average income in your area is $15,000. The average income in Monroe in Ouachita Parish, 40 or 50 miles away, is $27,000. Some would argue that it costs less to operate that hospital in Rayville than it would in Monroe. Look at the facts and the numbers on average income which you just submitted.

But I think what you are saying is that the differential is just killing you. Tell us why.

Mr. COOPER. Well, the differential hurts us quite a bit, and the fact that the urban areas—for instance, the average in the Monroe area on Medicare patients is less than 40 percent, indicating that 60 percent of their patients probably are paying full bill charges. We don't have that luxury.

Senator Breaux. So, the point is that you have a lot more Medicaid and Medicare patients than they do who can depend on private insurance or a paying patient perhaps.

Mr. Cooper. That is correct.

Senator Breaux. Okay, thank you.

The Chairman. Senator Pressler.

Senator Pressler. Let me ask you this question. A lot of hospitals in your area have closed. Many others have cut back significantly on their services. It seems to me that a key issue is the pay of nurses and physicians. You have had a lot of experience in paying nurses and physicians.

How can we get at this problem and what can the Federal Government do?

Mr. Cooper. Well, we find in our area that we are having to, as I alluded to, provide scholarships for our nurses so that at this point in time, 60 percent of the nurses who practice in our hospital are nurses that we sent through school.

I appeared before the Louisiana State——

Senator Pressler. And they stay with you for how long? How many years do they stay with you?

Mr. Cooper. The contract requires that they stay for the number of years we put them through school. So, if they go through a two-year A.D. program, then they are obligated to stay with us for two years or if they leave, they have to pay the money back with interest. If they go through a four-year B.S. program, they are obligated to stay with us for four years.

Senator Pressler. And 60 percent of your nurses are now in that program?

Mr. Cooper. People that we have had to send to school.

Senator Pressler. So, that is pretty expensive. Essentially, you pay their salary plus their college tuition.

Mr. Cooper. That is correct, including uniforms, watches, and white shoes.

Senator Pressler. Would you be better off paying an increase in salary to attract nurses?

Mr. Cooper. It may very well be. We really haven't broken that down to determine which would be the better of the two, but all I can tell you is that if I raise my nurses $1 an hour, the urban areas are going to raise theirs $1.50 an hour. They are going to try to stay ahead of the game.

Senator Pressler. And what about doctors and the pay issue? What is your experience there? What does it cost you to get doctors to rural areas?

Mr. Cooper. We have been very fortunate in our area in recruiting doctors. We have had to offer no guarantees as far as financial inducements. We are, however—I think if you will look at the charts on the back of my report, you can see that the utilization of our Delhi hospital is drastically reduced. We no longer provide obstetrical services at either hospital because of tremendous increases in malpractice, and we are at the point now of trying to recruit an

OB-GYN doctor at the Delhi, and we anticipate having to pay about $150,000 plus his first year's malpractice.

Senator PRESSLER. Yes, but what does it cost you to hire each physician including their malpractice insurance?

Mr. COOPER. The total cost for an OB-GYN doctor, for instance, would be about $175,000 a year.

Senator PRESSLER. And how much of that is insurance?

Mr. COOPER. About $25,000.

Senator PRESSLER. So, you are paying him $150,000 and then you buy him insurance.

Mr. COOPER. Right.

Senator PRESSLER. Which is $25,000. And that is a beginning physician is it, or is that——

Mr. COOPER. Yes.

Senator PRESSLER. Does he get an annual increase, generally speaking? How does it work?

Mr. COOPER. That is correct.

Senator PRESSLER. After he is in practice for ten years, how much is he making?

Mr. COOPER. Hopefully, after ten years, we won't be paying him anything. He will be generating enough money to cover his own guarantee. We feel that the business is there as far as obstetrics is concerned, but finding a doctor who is willing to move to a rural area is very difficult.

Senator PRESSLER. Thank you very much.

The CHAIRMAN. Senator Simpson.

Senator SIMPSON. Mr. Chairman, I thank you.

They are very interesting remarks you share with us. Because your State is very similar to ours in the sense of the oil industry and becoming so dependent upon oil and gas, it just sent reverberations through the whole State just as it has done in Louisiana, and I guess we are one of the most rural of States. 27 of the 30 hospitals in Wyoming are classified as rural for purposes of Medicare reimbursement.

So, we have, you know, a very sparse population, less than any Congressional district in the United States with a total population of 460,000 people. It is called the land of high altitude and low multitude, and I think that is probably right.

We are a frontier State in that sense and long distances between towns, and this outlier thing is just terrible—I get it wherever I go. Hospital administrators gather together and say what are we going to do about that.

With your background and the knowledge of the situation, Mr. Cooper, what are we going to do with the problem of the outlier, not just the long-term outlier or the cost outlier but the issue itself and how to limit those losses, what are we going to do with that?

Mr. COOPER. I think I will start this, and then if I may, I will let Mr. Jurovich continue.

We have seen many of these outlier problems or fiascos, if you will, where we have patients in the hospital for days upon end on respirators. I anticipate that with the advent of AIDS and other such disorders—TPA now that is being used directly after a heart attack. The cost of the drug now is $2,200. We are getting paid on a DRG for heart attack in the rural areas about $3,200.

I think you are going to see an increase and, hopefully, some of the new legislation being passed by Congress will help to some extent, but we feel it is not nearly enough.

Mr. Jurovich.

Mr. JUROVICH. Senator, the outlier problem, especially for the rural hospitals, can be totally catastrophic. We have one case in south Louisiana where a hospital experienced a $350,000 cost outlier of which they got back about $20,000 from Medicare. This one case cost that hospital its entire year's bottom line plus.

I think if there is anything you can do to relieve the rural hospitals for this catastrophic coverage for one case or two cases which literally wipes them out from even recouping any kind of a return in a given year would be most helpful. But those singular type cases in that setting can be specifically disastrous. It can wipe out all their reserves at one time.

Senator SIMPSON. Well, catastrophic is what it will be if we cannot begin to sort it out at the Federal level. Payment for health care could break the bank, and that will be our problem. At least we did—and I think all of us supported—the catastrophic health care bill which we just passed, it has some good stuff in it.

But, you know, health care is expensive, and the long-term health care which Congressman Pepper was so interested in will also come back after it goes through the proper committee procedures. That will be a tremendous expense, and it will fall upon both those who receive the benefit and taxpayers of all ages.

So, it is a serious problem, and you described it as catastrophic. Just one final question—are there any ways to insure a hospital against these tremendous outlier losses that you know of? You are both in that business.

Mr. COOPER. Unless you are willing to adopt some of the thoughts and ideas of Governor Lamm about senior citizens and certain inalienable rights that they have, I don't seen any way around it, Senator. We are going to have people who get sick, and we are going to have to take care of them the best we know how.

At this point, I think we are going to continue to have outliers. As I say, I think it is going to increase with AIDS. When the AIDS gets into the senior citizen population, we are going to have problems.

Senator SIMPSON. Well, you have outlined the seriousness of the problem. Our job is to try to resolve that in the midst of a catastrophic bill that we don't know the cost of and a long-term health care bill that we haven't formulated but we know it will come back next session and hang on tight, along with us.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you very much, Mr. Cooper, for your testimony. It is very much appreciated.

Mr. COOPER. Thank you.

The CHAIRMAN. Our next witness is Jim Oliverson, a rural hospital administrator of Saint Luke's Community Hospital in Ronan, Montana. He formerly managed a rural hospital that was forced to close. He also is a trustee of the Montana Hospital Association and is presenting testimony on behalf of himself and the association.

I want to commend you, Mr. Oliverson, and others in the Montana Hospital Association for the action that the Montana Legislature took in passing legislation to create a licensure for a new category of rural health facilities known as the "Medical Assistance Facilities".

Mr. Oliverson, I have just learned that Dr. Roper has agreed to provide some help in making sure that the medical assistance facilities demonstration projects can go forward.

Please proceed. We are anxious to hear your testimony, and we think the MAF proposal is very worthwhile and based on very solid experience.

I note that you were administrator of Saint Luke's Hospital, I believe, beginning in 1971. That is 17 years ago.

Mr. OLIVERSON. Yes, sir.

The CHAIRMAN. You are still there. Congratulations.

Mr. OLIVERSON. Thank you. It won't last much longer perhaps, but thank you.

STATEMENT OF JIM OLIVERSON, TRUSTEE, MONTANA HOSPITAL ASSOCIATION, AND ADMINISTRATOR, SAINT LUKE'S COMMUNITY HOSPITAL, RONAN, MT

Mr. OLIVERSON. Thank you, Mr. Chairman and members of the committee.

My name is Jim Oliverson. I am Administrator of Saint Luke's Community Hospital, a 22-bed facility in Ronan, Montana and, as Senator Melcher said, I am a member of the Board of Trustees of the Hospital Association.

Until February of this year, I was also the Administrator of Mission Valley Hospital, a small 18-bed facility in St. Ignatius, Montana. On the last day of February, the board of directors voted to close the Mission Hospital, and I can assure you that it was an extremely painful decision to close that hospital, but it was made somewhat easier by the fact that St. Ignatius and Ronan are 15 miles apart, and they are served by essentially the same staff and administration.

Some communities are not so fortunate. Many communities west of the Mississippi meet the designation of being frontier areas, that is, they have fewer than six residents per square mile. Frank Popper, a demographer at Rutger's University, found that 45 percent of the land mass of the nation meets the standard of being frontier. The four States of Washington, Alaska, Idaho, and Montana comprise over 25 percent of the nation's land mass but a little more than 5 percent of the nation's population.

Health care services, when they exist at all in frontier areas, are, by definition, small and isolated. They also provide access to needed services in their communities.

When a hospital in a frontier area closes, it is not simply a matter of inconvenience. The travel times limit access to routine and preventive care and totally eliminate access to timely emergency care. Western States already have accidental death rates per 100,000 that are some 50 percent higher than the national average.

In Montana, there have been other rural hospital closures in the last two years. The hospitals in Jordan and Ekalaka closed because of an inability to recruit and retain physicians. As Senator Shelby said earlier, you can't have hospitals without doctors.

Health care recruitment, the ability to attract qualified doctors and nurses, is not the only problem facing small rural hospitals. There are many other problems that some of the other witnesses have talked about and I am sure others will touch on later, but I will outline a few for you.

Changes in third party insurance, both public and private, and patterns of physician practice have caused an abrupt and marked decline in hospital utilization. Hospitals with fewer than 30 beds in Montana experienced 30 percent occupancy rates in 1986.

Medicare, Medicaid, and the Indian Health Service all reimburse on the basis of DRG's, diagnosis related groups. Payments for care rendered these patients has not kept pace with the actual increases in health care costs.

Under this fixed price payment methodology, hospitals are also at risk for long or unusually expensive cases known as outliers that Senator Simpson was touching on. A single outlier can have devastating effects on a small hospital. One of my neighboring facilities, the Clark Fork Valley Hospital in Plains, lost, on a single patient, over $61,000. Under Medicare, rural hospitals are paid 20 to 40 percent less than urban hospitals providing the same care for the same diagnosis.

Smaller hospitals are at risk because we don't have as great an opportunity to shift costs to private payers or commercial insurers. It is not unheard of for a small hospital on or close to an Indian reservation to be 90 percent DRG-utilized by the sum of Medicare, Medicaid, and Indian Health Service. From that remaining 10 percent of the charge payers, people who are paying charges, we must subtract approximately 4 percent additionally for bad debts and charities. So, you can see the margin gets pretty lean.

Very small hospitals also find some regulations or the conditions of participation extremely burdensome. Regulations that were written with the average hospital of 150 beds in mind sometimes don't make sense in a small hospital of 15 beds.

These regulations contribute to a hospital's fixed costs and, therefore, increase the average cost per case in an area of decreased utilization. For example, a hospital that has 10 beds and an occupancy rate of 25 percent will have days, occasionally, when there are no patients in the hospital, and I can speak to that. On these zero census days, the hospital still must staff according to the minimum standards of the regulations.

The Montana Legislature has recognized the special problems of very small isolated rural facilities and has taken action. The action they have taken is not to prop up ailing frontier hospitals at any price, and I think that is important. It is not to prop up ailing hospitals at any price but to retain access to needed services by creating a downsizing option that was previously unavailable. The Legislature created a new type of health care service known as the Medical Assistance Facility or MAF.

A MAF is a health care facility that A) provides in-patient care to ill or injured patients prior to their transportation to a hospital or provides in-patient medical care to persons needing that care for a period of no longer than 96 hours or four days and B) either is located in a county with fewer than six residents per square mile or is located more than 35 miles from the nearest hospital.

MAF's must meet State licensure and certification requirements. These licensure and certification requirements are a synthesis of the Medicare Conditions of Participation for hospitals and rural health clinics. At the same time, the licensure and certifications requirements lessen the regulatory burden on small facilities, protect the safety of the public and assure that the facilities provide quality services.

The criteria also make provisions for the use of physician extenders such as nurse practitioners and physician assistants, just as the rural health clinics do now. An MAF can be staffed with a combination of physicians and allied health professionals or simply with a physician extender operating under established protocols and under the periodic supervision of a physician.

MAF's are not hospitals. The four-day upper limit on length of stay means that they will treat only low intensity, short-term acute care patients. By necessity, this means they will treat a narrow range of patients. Because the scope of services is reduced, the regulations governing care can also be reduced.

MAF's will solve some of the problems of frontier hospitals. The flexibility in regulations will reduce fixed costs. The use of physician extenders will allow a facility to remain open that is not staffed by a physician. All other things being equal, a doctor may choose a community with a MAF over one with no health facility at all.

Because of the limit on length of stay, a facility's exposure to outliers is limited. MAF's do not ensure the presence of health services in frontier areas but certainly create conditions under which a properly managed facility should be able to survive.

We believe that the MAF concept is a reasonable alternative to hospital closure. The Montana Hospital Association has requested from the Health Care Financing Administration a four-year grant to demonstrate the utility and desirability of MAF's as a new type of frontier health care facility.

Our association has also applied for a waiver of two Medicare/Medicaid regulations. First, we asked that Medicare and Medicaid DRG's and corresponding policies be used as the basis of reimbursement for program patients during the demonstration project.

Second, we requested that the State of Montana licensure standards for MAF's be accepted as the Medicare/Medicaid Conditions of Participation. Although we know HCFA is interested in the concept, we don't know yet whether we will be awarded the grant.

Although grant monies would be useful to facilitate a study of MAF's, a grant is not as important to us as the concept of the waivers. If Medicare and Medicaid refuse to reimburse MAF's for the services, this experiment is doomed from the beginning.

In closing, Senator, I would like to thank the committee for inviting me to testify. Rural health and aging are linked more closely than one would guess at first glance. In Montana, counties with fewer than 10,000 residents have a population rate for individuals 65 years of age and older of 15.3 percent as compared to 11.2 percent for counties with greater than 10,000 residents. This means that rural counties have a ratio of over 65 residents that is 37 percent greater than do more urban counties. So, in a very real sense, access to rural health services is access of the elderly to those services.

Moreover, many of those forced to travel to another location for care by the closure of a frontier health facility are those least able to travel long distances. MAF's are intended to maintain frontier accessibility to basic acute and emergency care services.

Thank you.

[The prepared statement of Mr. Oliverson follows:]

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MONTANA HOSPITAL ASSOCIATION

testimony of
James Oliverson
before the

SENATE SPECIAL COMMITTEE ON AGING

JUNE 13, 1988

MONTANA HOSPITAL ASSOCIATION
TESTIMONY OF JAMES OLIVERSON BEFORE THE
SENATE SPECIAL COMMITTEE ON AGING
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Mr. Chairman, Members of the Committee, I am James Oliverson, administrator of St. Luke Community Hospital, a 22 bed facility in Ronan, Montana, and a member of the Board of Trustees of the Montana Hospital Association. Until February of this year, I was also the administrator of Mission Valley Hospital, an 18 bed facility in St. Ignatius, Montana. On the last day of February, the Board of Trustees voted to close Mission Valley. It was an extremely painful decision to close the hospital, but it was made somewhat easier by the fact that St. Ignatius and Ronan are fifteen miles apart, and are served by essentially the same hospital staff and administration. Some communities are not so fortunate. Many communities west of the Mississippi meet the designation of being frontier areas - that is, they have fewer than six residents per square mile. Frank Popper, a

DEMOGRAPHER AT RUTGER'S UNIVERSITY, FOUND THAT 45 PERCENT OF THE LAND MASS OF THE UNITED STATES MEETS THE STANDARD OF BEING FRONTIER. THE FOUR STATES OF WASHINGTON, ALASKA, IDAHO AND MONTANA COMPRISE OVER 25% OF THE NATIONAL LAND MASS, BUT A LITTLE MORE THAN 5% OF THE NATION'S POPULATION.

HEALTH CARE SERVICES, WHEN THEY EXIST AT ALL IN FRONTIER AREAS, ARE, BY DEFINITION, SMALL AND ISOLATED. THEY ALSO PROVIDE ACCESS TO NEEDED SERVICES IN THEIR COMMUNITIES. WHEN A HOSPITAL IN A FRONTIER AREA CLOSES, IT IS NOT SIMPLY A MATTER OF INCONVENIENCE. THE TRAVEL TIMES LIMIT ACCESS TO ROUTINE AND PREVENTIVE CARE, AND TOTALLY ELIMINATE ACCESS TO TIMELY EMERGENCY CARE. WESTERN STATES ALREADY HAVE ACCIDENTAL DEATH RATES PER 100,000 THAT ARE SOME FIFTY PERCENT HIGHER THAN THE NATIONAL AVERAGE.

IN MONTANA, THERE HAVE BEEN TWO OTHER RURAL HOSPITAL CLOSURES IN THE LAST TWO YEAR. THE HOSPITALS IN JORDAN AND EKALAKA CLOSED BECAUSE OF AN INABILITY TO RECRUIT AND RETAIN PHYSICIANS. YOU CAN'T HAVE A HOSPITAL WITHOUT DOCTORS. HEALTH CARE RECRUITMENT - THE ABILITY TO ATTRACT QUALIFIED DOCTORS AND NURSES - IS NOT THE ONLY PROBLEM FACING SMALL RURAL HOSPITALS. THERE ARE MANY PROBLEMS THAT, I'M CERTAIN, THE OTHER WITNESSES WILL TESTIFY TO. I WILL OUTLINE A FEW.

CHANGES IN THIRD PARTY INSURANCE (BOTH PUBLIC AND PRIVATE), AND PATTERNS OF PHYSICIAN PRACTICE HAVE CAUSED AN ABRUPT AND MARKED DECLINE IN HOSPITAL UTILIZATION. HOSPITALS WITH FEWER THAN THIRTY BEDS IN MONTANA EXPERIENCED 30 PERCENT OCCUPANCY RATES IN 1986. MEDICARE, MEDICAID AND THE INDIAN HEALTH SERVICE ALL REIMBURSE ON THE BASIS OF DIAGNOSIS RELATED GROUPS, OR DRGS. PAYMENTS FOR CARE RENDERED THESE PATIENTS HAS NOT KEPT PACE WITH THE ACTUAL INCREASES IN HEALTH CARE COSTS. UNDER THIS FIXED PRICE PAYMENT METHODOLOGY, HOSPITALS ARE ALSO AT RISK FOR LONG OR UNUSUALLY EXPENSIVE CASES, KNOWN AS OUTLIERS. A SINGLE OUTLIER CAN HAVE DEVASTATING EFFECTS ON A SMALL HOSPITAL. ONE OF MY NEIGHBORING FACILITIES, THE CLARK FORK

Valley Hospital in Plains, Montana, lost, on a single patient, over $61,000. Under Medicare, rural hospitals are paid 20-40 percent less than urban hospitals providing the same care for the same diagnoses.

Smaller hospitals are at risk because they do not have as great an opportunity to shift costs to private payers or commercial insurers. It is not unheard of for a small hospital on or close to an Indian reservation to be 90 percent DRG-utilized by the sum of Medicare, Medicaid and Indian Health patients. From the remaining 10 percent of charge payers, one must subtract approximately 4 percent additionally for bad debts and charity.

Very small hospitals also find some regulations - conditions of participation - unduly burdensome. Regulations that were written with the average hospital of 150 beds in mind, sometime do not make sense in a hospital of 15 beds. These regulations contribute to a hospital's fixed costs and, therefore, increase the average cost per case in an area of decreased utilization. For example, a hospital that has 10 beds, and an occupancy rate of 25 percent, will have days, occasionally, when there are no patients in the hospital. On these zero census days, the hospital still must staff according to the minimum standards of the regulations.

The Montana Legislature has recognized the special problems of very small isolated rural facilities, and has taken action. The action they have taken is not to prop up ailing frontier hospitals at any price, but to retain access to needed services by creating a downsizing option that was previously unavailable. The legislature created a new type of health care service known as the Medical Assistance Facility, or MAF.

A MAF is a health care facility that A) provides inpatient care to ill or injured patients prior to their transportation to a hospital, or

PROVIDES INPATIENT MEDICAL CARE TO PERSONS NEEDING THAT CARE FOR A PERIOD OF NO LONGER THAN 96 HOURS (OR FOUR DAYS), AND B), EITHER IS LOCATED IN A COUNTY WITH FEWER THAN SIX RESIDENTS PER SQUARE MILE, OR IS LOCATED MORE THAN 35 MILES FROM THE NEAREST HOSPITAL.

MAFs MUST MEET STATE LICENSURE AND CERTIFICATION REQUIREMENTS. THESE LICENSURE AND CERTIFICATION REQUIREMENTS ARE A SYNTHESIS OF THE MEDICARE CONDITIONS OF PARTICIPATION FOR HOSPITALS AND RURAL HEALTH CLINICS. AT THE SAME TIME, THE LICENSURE AND CERTIFICATION REQUIREMENTS LESSEN THE REGULATORY BURDEN ON SMALL FACILITIES, PROTECT THE SAFETY OF THE PUBLIC, AND ASSURE THAT THE FACILITIES PROVIDE QUALITY SERVICES.

THE CRITERIA ALSO MAKE PROVISIONS FOR THE USE OF PHYSICIAN EXTENDERS, SUCH AS NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS, JUST AS RURAL HEALTH CLINICS DO NOW. A MAF CAN BE STAFFED WITH A COMBINATION OF PHYSICIANS AND ALLIED HEALTH PROFESSIONALS, OR SIMPLY WITH A PHYSICIAN EXTENDER OPERATING UNDER ESTABLISHED PROTOCOLS, AND UNDER THE PERIODIC SUPERVISION OF A PHYSICIAN.

MAFs ARE NOT HOSPITALS. THE FOUR-DAY UPPER LIMIT ON LENGTH OF STAY MEANS THAT THEY WILL TREAT ONLY LOW-INTENSITY SHORT-TERM ACUTE CARE PATIENTS. BY NECESSITY, THIS MEANS THEY WILL TREAT A NARROW RANGE OF PATIENTS. BECAUSE THE SCOPE OF SERVICES IS REDUCED, THE REGULATIONS GOVERNING CARE CAN ALSO BE REDUCED.

MAFs WILL SOLVE SOME OF THE PROBLEMS OF FRONTIER HOSPITALS. THE FLEXIBILITY IN REGULATIONS WILL REDUCE FIXED COSTS. THE USE OF PHYSICIAN EXTENDERS WILL ALLOW A FACILITY TO REMAIN OPEN THAT IS NOT STAFFED BY A PHYSICIAN. ALL OTHER THINGS BEING EQUAL, A DOCTOR MAY CHOOSE A COMMUNITY WITH AN MAF OVER ONE WITH NO HEALTH FACILITY AT ALL.

BECAUSE OF THE LIMIT ON LENGTH OF STAY, A FACILITY'S EXPOSURE TO OUTLIERS IS LIMITED. MAFs DO NOT INSURE THE PRESENCE OF HEALTH

SERVICES IN FRONTIER AREAS, BUT CREATE CONDITIONS UNDER WHICH A PROPERLY MANAGED FACILITY SHOULD BE ABLE TO THRIVE.

WE BELIEVE THAT THE MAF CONCEPT IS A REASONABLE ALTERNATIVE TO HOSPITAL CLOSURE. THE MONTANA HOSPITAL ASSOCIATION HAS REQUESTED FROM THE HEALTH CARE FINANCING ADMINISTRATION A FOUR-YEAR GRANT TO DEMONSTRATE THE UTILITY AND DESIRABILITY OF MAFS AS A NEW TYPE OF FRONTIER HEALTH CARE FACILITY.

THE ASSOCIATION HAS ALSO APPLIED FOR A WAIVER OF TWO MEDICARE/MEDICAID REGULATIONS. FIRST, WE ASKED THAT MEDICARE AND MEDICAID DRGS AND CORRESPONDING POLICIES BE USED AS THE BASIS OF REIMBURSEMENT FOR PROGRAM PATIENTS DURING THE DEMONSTRATION PROJECT.
SECOND, WE REQUESTED THAT THE STATE OF MONTANA LICENSURE STANDARDS FOR MAFS BE ACCEPTED AS THE MEDICARE/MEDICAID CONDITIONS OF PARTICIPATION. ALTHOUGH WE KNOW HCFA IS INTERESTED IN THE CONCEPT, WE DO NOT KNOW WHETHER WE WILL BE AWARDED THE GRANT. ALTHOUGH GRANT MONIES WOULD BE USEFUL TO FACILITATE A STUDY OF MAFS, A GRANT IS NOT AS IMPORTANT TO THE CONCEPT AS ARE THE WAIVERS. IF MEDICARE AND MEDICAID REFUSE TO REIMBURSE MAFS FOR THE SERVICES THEY PROVIDE, THIS EXPERIMENT IS DOOMED FROM THE BEGINNING.

IN CLOSING, I WOULD LIKE TO THANK THE COMMITTEE FOR INVITING ME TO TESTIFY. RURAL HEALTH AND AGING ARE LINKED MORE CLOSELY THAN ONE WOULD GUESS AT FIRST GLANCE. IN MONTANA, COUNTIES WITH FEWER THAN 10,000 RESIDENTS HAVE A POPULATION RATE FOR INDIVIDUALS 65 YEARS OF AGE AND OLDER OF 15.3 PERCENT, AS COMPARED TO 11.2 PERCENT FOR COUNTIES WITH GREATER THAN 10,000 RESIDENTS. THIS MEANS THAT RURAL COUNTIES HAVE A RATIO OF OVER 65 RESIDENTS; THAT IS 37 PERCENT GREATER THAN MORE URBAN COUNTIES. SO, IN A VERY REAL SENSE, ACCESS TO RURAL HEALTH SERVICES IS ACCESS OF THE ELDERLY TO THOSE SERVICES. MOREOVER, MANY OF THOSE FORCED TO TRAVEL TO ANOTHER LOCATION FOR CARE BY THE CLOSURE OF A FRONTIER HEALTH FACILITY ARE THOSE LEAST ABLE TO TRAVEL

LONG DISTANCES. MAFs ARE INTENDED TO MAINTAIN FRONTIER ACCESSIBILITY TO BASIC ACUTE AND EMERGENCY CARE SERVICES.

> The Montana Hospital Association is a trade association comprised of fifty-eight community and federal hospitals. The Association has served the interests of Montana hospitals for over 53 years.
>
> The Montana Hospital Association is a member of the Northwest Network, a coalition of hospital associations, which serves as a regional voice for rural hospitals in Idaho, Montana, Oregon and Washington.

The CHAIRMAN. Thank you very much, Jim.

A previous witness, Mr. Cordes from Wyoming, sought to establish, or at least to set out for the committee to ponder, what is our responsibility with respect to hospital care in rural areas. Perhaps what the Montana Legislature has done in the Medical Assistance Facilities Act is to provide part of that answer.

I want to commend the Montana Hospital Association and you for pioneering this proposal. I hope we will find that yes, indeed, this is a part of the answer to the challenge posed by Mr. Cordes.

Senator Burdick, do you have any questions of the witness?

Senator BURDICK. Yes, thank you, Mr. Chairman.

As Co-Chair of the Senate Rural Health Caucus, I co-signed a letter with Chairman Melcher directed to William Roper, the Administrator for HCFA. That letter supported the Montana Research and Education Foundation proposal to help develop and evaluate this new entity known as the Medical Assistance Facility.

So, as you can see, I am in full support of the project you just described.

Mr. OLIVERSON. Thank you.

Senator BURDICK. One of the reasons that I am particularly impressed by this proposal is because of the role of the non-physician providers. The North Dakota State Health Officer, Dr. Bob Wentz, recently stated that we overly restrict the practice privileges of nurses and other non-physician providers. I think your proposal will help to address that problem.

Is there anything else you can add that would further describe the role of these health professionals within an MAF?

Mr. OLIVERSON. I am not sure—do you mean what more they can do or what they will be doing, Senator?

Senator BURDICK. I want to know what more is possible. What more can you do?

Mr. OLIVERSON. What more can we do to extend the role of these physician extenders?

Senator BURDICK. To provide health services in this system.

Mr. OLIVERSON. I guess we will learn as we go along, Senator.

Senator BURDICK. You can't perform surgery, but you can do some other things, can't you?

Mr. OLIVERSON. That is correct. There are many things they can do. They basically multiply the physician. There are many tasks that a physician in a rural area does that they wouldn't need to do if they weren't the only one there such as doing histories and physicals and various types of research on their patients. So, the physician just becomes more efficient.

Senator BURDICK. For example, you have a serious case of whatever it is that needs attention, and you need to take that patient 50 or 100 miles away for better care. Do you have the ability to sustain care with blood supply or oxygen and things like that?

Mr. OLIVERSON. Surely.

Senator BURDICK. Until you get them to the point of destination?

Mr. OLIVERSON. Absolutely. We have the ability to stabilize it, and we are blessed in many of the rural communities with very fine ambulance crews. As someone testified earlier, many of the metropolitan areas have helicopters. So, if we get over our heads—and we realize it very quickly—we simply call to them for help, and if the weather is one that doesn't permit it, then you do it by ground ambulance.

However, I think most of us are very aware that there are things we can't and shouldn't be getting involved in. So, we do our best to stabilize the patient and get him out.

Senator BURDICK. Thank you.

The CHAIRMAN. Thank you very much, Jim.

We will call our next witness now, and I yield to Senator Burdick to introduce him.

Senator BURDICK. Dr. Hart.

Doctor, I would like to welcome you to the hearing today. I also want the record to show that this North Dakotan assumes a leadership role not only in my State and the surrounding region in terms of rural health, but he is also the president-elect of the National Rural Health Association.

This association has worked diligently and demonstrated a tremendous commitment to finding ways to better meet the health needs of rural Americans.

Dr. Hart, we appreciate your taking time from your busy schedule to share your expertise with us today. Welcome.

Mr. HART. Thank you, Senator.

STATEMENT OF J. PATRICK HART, PH.D., DIRECTOR, OFFICE OF RURAL HEALTH SERVICES, CENTER FOR RURAL HEALTH SERVICES, POLICY AND RESEARCH, GRAND FORKS, ND

Mr. HART. Senator Burdick, Mr. Chairman, Members of the Special Committee on Aging, my name is Patrick Hart. I am the Director of the Office of Rural Health Services at the Center for Rural Health at the University of North Dakota.

During the past two and a half years, I have had the opportunity to spend a fair amount of my time working in an administrative and technical assistance capacity on a project called ARCH, Affordable Rural Coalition for Health. I would like to extend my great appreciation for the opportunity to talk about this project today and tell you a little bit about the experiences and the lessons that we have learned so far.

In way of context, it seems to me that the challenges facing rural health care and hospitals in particular are like a jigsaw puzzle, a big complex one that you lay out on your dinner table and work for hours at. A part of the pieces are going to be put together at the Federal level by the government and a part at the State level by innovative projects like the Medical Assistance Facility project just described. Finally a part of the pieces will be put together at the local level.

I want to talk today about the ARCH project in the sense that it is an example of how local people, drawing on local talent, using local commitment and resources with just a small amount of external resources can do a great deal in solving their part of the puzzle and bringing to bear their solutions.

The ARCH project is a partnership or joint effort. It is a joint effort of the Center for Rural Health at the University of North Dakota, the Lutheran Hospitals and Home Society of Fargo, North

Dakota, and 18 communities in Montana, Colorado, and North Dakota.

The funding for the project is being provided by the W.K. Kellogg Foundation, about $1.4 million, and there is about an equivalent amount being provided by the organizations that I just named, including the rural communities.

This project is directed at restructuring the role of the small rural hospital and the community health system of which it is a part. This means changing the mission and structure of the small rural hospital, and it means working with a very valued institution in the community.

I had this brought home to me by the people in the ARCH project one time talking about the changes in rural health care and the implications of the changes for rural communities. One person said that when he goes to the city, when he travels out of State and people ask him where he is from, he says I was born in New Rockford.

He said, you know, my mom and dad were born there, and my brothers and sisters were born there—if these changes mean that our hospital goes, in fact, there won't be any more people ever who can say they were born in New Rockford. So, it is an emotional issue that requires the commitment and participation of people from rural areas.

A total of 18 communities, each having a hospital, have been involved in the ARCH Project. Eleven of the 18 are communities of less than 2,500 population. Fourteen of the hospitals have 50 beds or less. In terms of the bottom line, at the time we started, 8 of the hospitals had operating expenses that exceeded their revenues and clearly were in difficulty.

I want to point out three major concepts that go with this project. One is that of local leadership. The starting point for local leadership in this project was recruiting local people to work as community organizers. Another part of local leadership was identifying leaders from five major sectors, commerce, education, government, health, and religion, to work on this project by serving on what we call the local ARCH board.

The second concept that is very important is community-wide involvement. As I mentioned, we are talking about fundamental changes in the rural health care system. Consequently, we need to have the general public involved. So, the people who were representatives of commerce, education, government, health, and religion sought out the cooperation and assistance of people from throughout the community in each of the five critical sectors.

The third major concept is the importance of a focal point for community commitment. It is one thing to have people who are willing to work in organizing. It is another thing to get the leadership involved and to involve a lot of people. You also have to have a focal point. That was provided by grants for local health system restructuring of about $23,000 per community from the W.K. Kellogg Foundation, which were matched by an equivalent amount of local money.

So, there was local leadership, community involvement, and a focal point for community commitment.

Several kinds of projects have been implemented. Each project sought to use the $23,000 plus matching money to achieve one or more of the following aims: Diversifying services so as to improve access; ensuring that people used services locally rather than leave the area to obtain basic services; and improving cooperation and coordination among local providers.

I want to point out that there are about 40 activities across these projects. Of those 40, 11 were targeted directly to the needs of seniors, 8 were targeted to the general adult population and had very strong components for seniors. So, 19 or about half of these activities were aimed at seniors.

I would like to add just a little bit more to the background that I have presented today. We worked with two kinds of sties. One was what is called a consortium site in which three or more hospitals worked together, and the other was a single site.

If you look at a map of your State in terms of rural hospitals, you will find clusters of two, three, and four hospitals in close proxmity. It is important to have cooperation and networking among them. This was the main thrust in the consortium sites.

There are other cases where there will be one hospital and it will be fairly isolated. In this case it is essential to encourage networking a among local service. It is very important that these two cases be treated somewhat differently because they require somewhat different strategies for restructuring.

I want to thank you very much for the opportunity to present background information about ARCH today.

[The prepared statement of Mr. Hart follows:]

Testimony on the

AFFORDABLE RURAL COALITION FOR HEALTH (ARCH) PROJECT: A COMMUNITY-BASED APPROACH TO RESTRUCTURING THE ROLE OF THE RURAL HOSPITAL

Presented by

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Before the

United States Senate
Special Committee on Aging

June 13, 1988

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AFFORDABLE RURAL COALITION FOR HEALTH (ARCH) PROJECT:
A COMMUNITY-BASED APPROACH TO RESTRUCTURING
THE ROLE OF THE RURAL HOSPITAL

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Mr. Chairman and Members of the Special Committee on Aging: My name is J. Patrick Hart. I am the Director of the Office of Rural Health Services and Associate Professor of Community Medicine and Rural Health at The Center for Rural Health Services, Policy and Research, University of North Dakota, Grand Forks, North Dakota. During the past two and one-half years I have worked in an administrative and technical assistance capacity on the Affordable Rural Coalition for Health (ARCH) demonstration project. The ARCH demonstration project is an example of how local people drawing on local talent, commitment and resources together with a minimal level of outside resources can do their part in solving the complex problems of organizing and delivering health care in our nation's rural communities. I wish to offer my sincere appreciation for the opportunity to share with you the experiences and lessons learned thus far in the ARCH project.

Background

Rural hospitals and the communities that they serve are facing unparalleled challenges associated with the unique demographic, epidemiological, economic, financing and regulatory environments in which they exist. Each of these environments influence the organization and delivery of health care in rural areas. Consequently, each environment is a focal point to consider in identifying ways in which adjustments can be made in the structure of local health systems and in which changes in selected environmental factors might enhance the provision of health care to rural Americans.

Demographic Environment

The accelerated population growth that took place in rural America during the 1970's has ceased. Rural places are characterized now by low rates of population growth and in many cases a declining population (Beale and Fuguitt, 1986). In addition, rural areas contain a higher proportion of elderly than do metropolitan areas with older people constituting about 10 percent of the metropolitan population and about 12 percent of the nonmetropolitan population (National Institute on Aging, 1988). It is also generally the case that in rural areas the proportion of elderly increases as the size of the community decreases thus creating a disproportionate demand for services for the elderly in smaller rural communities.

Epidemiological Environment

One of the environmental factors to be considered in decisions regarding the organization and delivery of health services in rural areas is the health status of the people residing in those areas. Some of the characteristics that serve to distinguish rural from urban areas with regard to health status are as follows:

1. Injury death rates are substantially higher for rural than urban areas for a variety of causes associated with machinery and electricity, motor vehicles, climate and natural environment, and selected homicide and suicide causes;

2. Persons in nonmetro areas have higher rates for five of six chronic condition groupings used by the National Health Interview Survey than do persons in metro areas;

3. Persons in nonmetro areas have a slightly higher rate of activity limitation due to chronic conditions than do persons in metro areas; and,

4. Death rates for hypertension and cerebrovascular diseases are generally higher for persons in nonmetro than metro areas (Norton and McManus, 1987).

With regard to the health of rural older people, it is the case that older people in nonmetro areas report poorer health, greater degrees of limitation in functioning, more illness, higher duration of illness, and longer hospitalization than persons in metro areas (National Institute on Aging, 1988). In addition to differences in health status between older people in rural and urban areas, there is evidence of differences in health status of older persons who reside in rural nonfarm and rural farm locations (National Institute on Aging, 1988; Coward and Cutler, 1987). The diversity in health status among older persons in urban and rural and farm and nonfarm residence suggests the need for considered targeting of programs and resources and variation in the organization and delivery of services to match the complexity of needs of elders in rural areas.

Economic Environment

The economic environment of rural hospitals differs from the environment of urban hospitals, shows diversity from place-to-place within rural America, and is generally troublesome. The traditional reliance of many areas of rural America on extractive or natural-resource economies clearly distinguishes rural places from urban places. There are variations, however, between rural areas with regard to local economy which result in differing and unique economic environments for rural hospitals. The following taxonomy of non-metropolitan counties developed by the U.S. Department of Agriculture suggests the diversity of economic environments that may exist for rural hospitals located in different types of counties:

1. Farming-dependent counties;

2. Manufacturing-dependent counties;

3. Mining-dependent counties;

4. Specialized government counties;

5. Persistent poverty counties;

6. Federal land counties; and,

7. Destination retirement counties (Cordes, 1987).

Although there is diversity among rural hospitals with regard to the economic environment within which they operate, there is considerable uniformity in the extent to which the economies of rural areas have suffered a downturn in the 1980's. The traditional rural industries of energy, forestry, agriculture, and light manufacturing have suffered in recent years due to external structural forces and international economic forces (Cordes, 1987). Also, although there has been considerable growth in the service portion of the nation's economy, the benefit has been disproportionately greater in urban than in rural areas (Cordes, 1987). The lagging economy in rural areas has effected rural hospitals and the communities they serve in a variety of ways including emigration of younger wage earners from rural areas and decreasing the attractiveness of rural communities to potential employers and health professionals.

Financial Environment

In recent years, rural hospitals have operated in a disadvantaged financial environment. The American Hospital Association's "Environmental Assessment for Rural Hospitals: 1988" points out some of the problems encountered by rural health. For example, Medicare's Prospective Payment System pays rural hospitals less per Diagnosis Related Group than is paid to urban hospitals which is a particularly salient problem given the high proportion of elderly patients residing in rural areas. Also, rural hospitals suffer financially from increasing levels of uncompensated care and from limited access to capital to renovate and restore facilities built in the 1940s and 1950s under the Hill Burton programs (Mullner, et.al., 1988; Fickenscher, 1986).

Current practices of Medicare reimbursement for physician services also contributes to a disadvantaged status for rural areas through lower levels of compensation for rural physicians than for their urban counterparts (Physician Payment Review Commission, 1987). Ongoing efforts to resolve the issues of equity in payment pertaining to geographic location, specialty, and cognitive versus procedural skills and to simplify the Medicare payment system would greatly enhance the conditions under which rural hospitals operate (Fickenscher, 1985).

Regulatory Environment

At present, many rural hospitals have taken steps to achieve operating efficiencies commensurate with the decline in admissions and length of stay that is characteristic of rural areas. They have decreased active beds, reduced staff and in some cases discontinued services (Robinson, 1987). The process of downsizing rural hospitals has, in large part, already occurred at the local level through environmental pressure and organizational response. The concern at the local level is that existing levels of reduction, as well as additional reduction of acute care services, must be supported at the state and federal levels.

Additional reductions would result in noncompliance with the criteria for hospital licensure. Consequently, action such as the creation by the Montana State Legislature of the Medical Assistance Facility (Montana Legislature, SB 385) a new category of licensure which provides for low-intensity acute care services to short-term inpatients should be lauded. Such approaches should be thoroughly explored by states as a promising adjunct to local initiative.

Support for efforts to establish new categories of licensure that would assist rural hospitals to further downsize and restructure is needed at the federal level. For example, at present Medicare and Medicaid will not reimburse for the level of service represented by the Medical Assistance Facility. Support in the form of waivers and funds for research and demonstration projects to examine the feasibility and impact of new categories of licensure is needed.

Background Summary

The environments within which rural hospitals carry out their mission of service to rural America are unique in the sense that they differ in many salient ways from the environments of urban hospitals. The environments of rural hospitals differ from their urban counterparts in terms of population size, population growth and density, proportion of elderly, and health problems and conditions of rural residents. Also, the extractive or natural-resource based economy and the recent downturn of the economy of many rural areas serves to distinguish the economic environment of hospitals in rural areas from those in urban areas. Rural hospitals also operate in relatively disadvantaged financial and regulatory environments in comparison to urban hospitals.

The fact that there are clear differences in the environmental challenges faced by rural and urban hospitals does not mean, however, that there is strict uniformity in the environments in which rural hospitals provide their services. There is diversity among rural areas in population size and density and in the proportion and health status of elderly residents. Rural areas also vary considerably in economic base. These variations, as well as others involving cultural and regional differences, call for a local perspective in identifying appropriate strategies for organizing and delivering health care.

The ARCH demonstration project described below is an example of how rural hospitals and the communities they serve can bring to bear a local perspective and local resources in an effort to respond in a responsible way to the challenges facing rural hospitals. Local efforts such as those embodied in the ARCH project together with efforts at the state and federal level to address economic, financial, and regulatory constraints are needed to assure access to affordable and quality care for rural Americans.

The Affordable Rural Coalition for Health (ARCH) Project

The ARCH project is a joint effort of The Center for Rural Health Services, Policy and Research at the University of North Dakota, Grand Forks, ND; Lutheran Hospitals and Homes Society (LHHS) of Fargo, ND, and 18 communities in Colorado, Montana, and North Dakota. The project is directed at a restructuring of the role of the small rural hospital and the community health system of which it is a part. The ARCH project seeks to preserve the small rural hospital as a community resource. It seeks, however, to preserve it in a form that is most appropriate for meeting local health care needs and that represents a realistic response to the changes that have occurred in the larger health care environment. This ultimately means redefining the mission of the hospital from its traditional focus on acute inpatient care to a more diversified and broader community-based orientation. The task of reorienting the direction of this valued community institution requires active participation and cooperation among local health and human service providers and the support of the people in the communities that they serve.

The W.K. Kellogg Foundation, Battle Creek, Michigan, has provided $1.4 million in funding for the four-year program. An additional $1.5 million in matching funds and in-kind contributions is being provided by The Center for Rural Health, LHHS, and the 18 participating communities.

ARCH Communities

The 18 communities that are participating in the ARCH project are divided into two kinds of project sites. One is a consortium site in which three or more hospitals and their communities have agreed to work together addressing their community health needs. The consortium sites are Akron, Brush, and Sterling, Colorado; Chester, Choteau, Conrad, Cutbank, and Shelby, Montana; and Ashly, Wishek, and Linton, North Dakota.

A different perspective is provided by communities that are participating as single sites. The single sites, all located in North Dakota, are Cavalier, Grafton, Hillsboro, Park River, Lisbon, Mayville, and New Rockford.

The population of the ARCH communities ranges from 935 to 15,602; 11 of the 18 communities have a population of 2,500 or less. The number of beds in the participating hospitals ranges from 11 to 92 with 14 of the hospitals having 50 beds or less. With regard to average daily census, the hospitals range from four to 36 with ten of the participating hospitals having an average daily census of ten or less.

Community Organizing Approach

The approach used in the ARCH project is based on community organizing principles. A community organizing approach was selected in order to involve community leaders, assure community-wide involvement and understanding of the need to refocus the mission of the hospital, and draw together health and social service providers. The ARCH community organizing process consists of the following stages which are shown in graphic form in Figure 1.

1. Recruitment and selection of local community organizing coordinators;
2. Intensive training of coordinators in community organization theory and methods, health care issues and management techniques, rural perspectives, and communication skills;
3. Entry of coordinators into the community through information contacts with representatives of the health, commerce, education, government and religious sectors of the community;
4. Formation of a local ARCH board consisting of community leaders who provide representation of the health, commerce, education, government and religious sectors of the community;
5. Implementation of a board development program to promote a team approach and increase awareness and understanding of salient rural health issues and problems and potential problem-solving strategies;
6. Assessment of community health needs, resources and utilization patterns to provide data for planning local projects;
7. Development of a proposal for a local ARCH project to be funded by Kellogg seed monies and local matching resources; and,
8. Implementation of the local ARCH project using seed monies and local matching resources for community mobilization.

The local ARCH projects will have as their focus on one or more of the following local project goals that have been set out as priorities:

(a) To enhance the coordination and cooperation between local health and human service providers and between local providers and regional sources of care;

(b) To maintain or increase the use of local health and human services by persons residing in the area; and,

(c) To enhance the accessibility and acceptability of local and regional health and human services.

Progress to Date

The first several months of the ARCH project were devoted to organizing and developing the program. An ARCH Policy Committee consisting of representatives of The Center for Rural Health and LHHS was appointed and a national advisory group was identified and brought together to provide guidance to the project. Project staff members were recruited and hired and the ARCH sites were selected.

The ARCH community organizing process was started in April of 1986 with the selection of five local community organizing coordinators from a field of 56 applicants. The coordinators attended a six-week training program held in part at The Center for Rural Health in Grand Forks and in part at the LHHS headquarters in Fargo.

Immediately following their training, the local coordinators returned to their communities. Three of the coordinators each have responsibility for working with a consortium site and the remaining two work with single sites. Their initial tasks were to establish an office in each community and to inform the community about the ARCH project through individual contacts, presentations to groups and through the local media. A community assessment consisting of a mail survey of residents was completed as was interviews with local health and social service providers.

The local coordinators also identified and selected persons who represent the five sectors of health, commerce, education, government, and religion to serve on their local ARCH boards. A board development program conducted by the local coordinator and project staff for the members of the local ARCH boards also has been completed.

The local ARCH boards, working with the local coordinator and project staff, began work in the Summer of 1987 on a local project proposal. The boards drew on the results of the community surveys, local provider interviews, and personal knowledge and observations. With the aid of the data and a community health system planning process each of the boards prepared a proposal aimed at (a) enhancing coordination between the hospital and other health and human service providers, (b) maintaining or increasing use of local services and (c) enhancing accessibility and acceptability of local and regional health and human services. The funding levels of the proposals were targeted at approximately $23,000 per community of seed monies with an equivalent local match of approximately $12,000 cash and $13,000 in-kind contribution. The project proposals received review and recommendations from the national advisory group, project staff, and the project policy committee and the communities began implementation of the projects in late fall and winter of 1987.

As of the date of this testimony the local projects have been in operation for approximately six months. Each project consists of a set of activities that are directed at one or more of the goals of coordination, local use of services, and access and availability of needed services. In addition to addressing the three goal areas the projects are cross-cutting with regard to age with some addressing the needs of elders, some the needs of young and middle-aged adults, and others addressing the needs of adolescents. The projects also encompass a variety of services including physical and mental health and social services. There are more than 40 activities contained in the local project workplans of the participating sites. Examples of the kinds of activities that are being carried out under the direction of the local ARCH boards are presented below.

Consortium Sites

- Alcohol Dependency/Recovery/Rehabilitation Program. Primary outpatient treatment program for alcohol involved youth and adults covering three county service area of participating hospitals.

- Regional network of support groups to serve six county area in northeast Colorado. Linkages among hospitals, nursing homes and community colleges. Support groups to include asthma/allergies, alzheimer, suicide loss, teen pregnancy, and emotional/mental dependency.

* Public awareness and education effort to communicate and promote consortium concept to area residents. Includes Farm Forum booth representing five consortium hospitals, consortium newsletter to each box holder, directory of consortium-wide services.

* Cooperative nurse aide training program to meet state requirements. Involves rotating use of shared audiovisuals and trainers.

* Creation of a Cooperative Health Services Organization (shared services organization) focusing on physical therapy, respiratory therapy, and dietary services using consortium hospitals as a hub for services to nursing homes and other provider organizations.

Single Sites

* Electronic home emergency response system providing 24 hours a day, seven days a week coverage used by patients recently released from hospital and nursing home and linking hospital, nursing home and a law enforcement as response system.

* Creation and support of interagency health, social service, education, economic development, and civic association forum to plan and coordinate services and fund raising.

* Community wellness project consisting of emergency care, newsletter, CPR, farm safety, and elderly wellness, and self-help programs which tie together hospital, extension service, senior center, and school system.

* Health education network to offer emergency medical technician, nursing assistant, and health services board development training programs which establishes linkages among hospital, emergency medical services and local college.

* County-wide directory of health and human services and central referral center developed out of interagency cooperation and coordination on directory development. Includes coordination and use of resources of interagency form and marketing students from university.

In addition to directing the implementation of the local projects the ARCH boards are involved in extensive resource raising activities. They have obtained volunteer assistance from providers, auxiliaries, senior groups, and church groups. Fund raising activities have included pledge drives, fund raising events, selling advertising for directories, charging membership fees and soliciting donations from local businesses. In addition to fund raising, those projects that involve direct services are generating revenues to help move them toward self-reliance.

Conclusion

At present, the ARCH project appears to be moving toward the overall project goal of identifying a process by which local talent and resources in rural areas can be mobilized to direct and participate in the restructuring of the local hospital and the community health system. The project, however, has not been without problems and pitfalls. Turf issues have arisen repeatedly and have not been resolved in every case. Problems have arisen also in the form of turnover of hospital administrators and overriding community issues that have at times placed the ARCH projects in the background of community affairs. Of the 16 hospitals that originally began the project, two have dropped out. One over the issue of turf and another due to competition of other sectors of the community in fund raising. On the positive side, two additional hospitals and their communities have joined the project through the efforts of local ARCH boards to expand the realm of cooperation and coordination.

The degree of success that has been achieved is based on three key concepts inherent to the ARCH process. One of the key concepts is that of leadership. The starting point for assuring local leadership was the recruitment, selection, and training of community organizing coordinators from the areas in which the sites are located. The project also sought leaders from each of the critical community sectors of commerce, education, health, government, and religion.

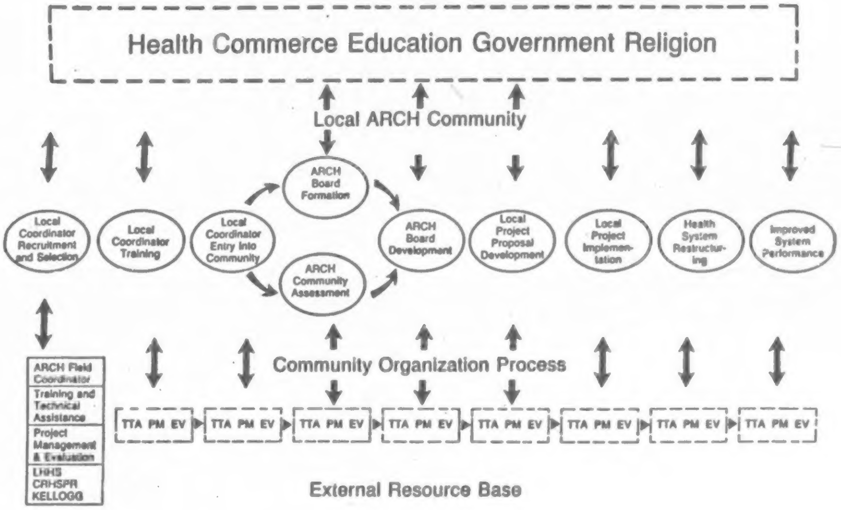
The second key concept of the ARCH community organizing approach is community-wide involvement. The leaders selected for the ARCH boards sought to inform and involve other residents from the community sectors that the leaders represented. Involvement of the general public was obtained also through the community assessment methodology which allowed residents to project their opinions and priorities into the process.

Finally, the ARCH process provided a focal point for community commitment. This key concept was operationalized through seed monies for the planning and implementation of a local project.

The implementation of these three concepts through the ARCH community organization process, together with the will of rural Americans to do their part in assuring health care for their family and neighbors appear to offer a part of the solution to the challenges of rural health care. Local action combined with commitment by states and the concern being shown by this hearing of the Senate Special Committee on Aging hold promise for the health of rural Americans. Thank you.

FIGURE 1

ARCH Community Organizational Model


Health Commerce Education Government Religion
Local ARCH Community
Local Coordinator Recruitment and Selection
Local Coordinator Training
Local Coordinator Entry Into Community
ARCH Board Formation
ARCH Community Assessment
ARCH Board Development
Local Project Proposal Development
Local Project Implementation
Health System Restructuring
Improved System Performance
ARCH Field Coordinator
Training and Technical Assistance
Project Management & Evaluation
LHHS CRHSPR KELLOGG
Community Organization Process
TTA PM EV
External Resource Base

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The CHAIRMAN. Mr. Hart, I want to thank you not only for presenting this testimony, but also for doing what you are doing in North Dakota through ARCH. I think that the type of solutions we need to have for rural hospitals are going to depend very much on leadership from people such as yourself. I want to thank you for that.

Senator Burdick.

Senator BURDICK. Dr. Hart, what kinds of needs for services are reported by the seniors who responded to your community assessment survey?

Mr. HART. Senator, as you know, we did a survey, and one of the aspects of that survey of the community was to identify needs in the areas of health promotion and disease prevention.

We had a strong response from seniors, which we defined as age 65 and over, for interest in stress management programs, exercise programs, and various kinds of nutrition programs. Also, when you look at the projects that were developed by community people on the basis of this data there were many programs that addressed the health promotion needs of seniors.

So, there is a tremendous interest in health promotion and disease prevention among the elderly in the rural areas. I think that is an area that is greatly needed, and it certainly was brought up at the local level.

Senator BURDICK. As you know, there is a nursing shortage developing in our country. How is this restructuring of hospitals and community health systems going to affect this shortage in rural areas?

Mr. HART. Well, I think right now, sir, we don't know exactly, but I think there are some positive things and perhaps some not so positive things. We are looking at a fundamental restructuring of rural health care that involves communities and a variety of health services working together. We have hospital, home health, public health, school health, and occasionally industrial nursing needs. We find that there is a broad range of nursing needs in rural areas.

Through the process of identifying how to pull a variety of services into a coalition and a full continuum of care, I think that we might be able to create jobs that have the kind of challenge that I think is sought in nursing. I would hope also that as we obtain equitable reimbursement for rural hospitals and carry out a creative reorganization of the job structure for rural nursing there would be salaries that would be competitive and create interest for nurses to work in rural areas.

Senator BURDICK. What kind of evaluation is being done, what things are you looking at, so that you know whether the projects have been successful?

Mr. HART. Well, we are looking at a number of things but we are interested in two broad areas. One is the structure of the health care system and the other is the performance of the health care system.

In the area of structure, we are looking very closely at coordination and cooperation. We are finding that interagency forums have been set up and that linkages and relationships are developing between the health services in the area and between the hospitals in the consortium sites.

The second aspect of structure is whether there are different services and different amounts and kinds of providers than when we started. It appears that there are indeed new services and, in some cases, new providers that are resulting from local projects.

We are also looking at performance, and we are examining performance in terms of whether a hospital or local health system could keep its people using local services when, in fact, those local services were there and available. We have base line data and we will look at how these projects affect use of local services over the long run.

We are also interested in basic access. We have base line data as to whether or not there were basic needs that were not being met. Some of the projects that are going into place right now are meeting needs that were there and that weren't being met earlier.

So, in conclusion we are looking at both the structure of the system and its performance.

Senator BURDICK. Thank you very much.

The CHAIRMAN. Thank you very much, Dr. Hart, for your testimony. It is very helpful.

Mr. HART. Thank you.

The CHAIRMAN. Our next witness is Tim Size who is Executive Director of the Rural Wisconsin Hospital Cooperative and is a spokesperson for the National Rural Health Care Association.

Mr. SIZE. Thank you for having me.

The CHAIRMAN. Thank you very much for being here, Mr. Size.

STATEMENT OF TIMOTHY K. SIZE, EXECUTIVE DIRECTOR, RURAL WISCONSIN HOSPITAL COOPERATIVE, SAUK CITY, WI, AND BOARD MEMBER, NATIONAL RURAL HEALTH CARE ASSOCIATION

Mr. SIZE. Given the time and the fact that I did give you written testimony, I think I will dispense with any remarks that specifically talk about some of the innovative work we and some of the other networks have been doing.

One thing I would like to say is it is clear that the problems facing rural hospitals require both private sector and public solutions. It is our feeling that on the private side, rural hospitals can no longer sustain themselves with what we frequently refer to as a John Wayne independence and autonomy.

We need to be looking for network types of solutions. I think the Kellogg ARCH project that you just heard described as well as the Robert Wood Johnson project we are participating in and the work of other cooperatives and networks around the country are good examples. However, that is all in the paper, and I won't speak further about it.

What I would like to talk about is the public side, because it is clear to me when more of the committee was here that there is quite a bit of interest in the Medicare issue; is something I refer to in my testimony and am very concerned about.

I think if we don't get the kind of changes we need in Medicare, we can be as creative as possible (and many of us have been), but it is not going to make enough difference.

My office is in Sauk City, Wisconsin which is just over the Wisconsin River from an urban county. I am frequently asked about this Medicare equity problem. I know the words to say why the hospitals, even after the recent budget reconciliation changes, across the river are getting 36 percent more payment, but that is not really an explanation. I can tell them the words, I know the litany, but I can't explain it. I can't tell them why their government in Washington is doing this.

There is a lot of talk and inferences that, on the one hand, rural hospitals are asking for a subsidy but, on the other hand, they are being paid less. Well, I don't understand subsidies to people who are getting paid less. I think the shoe is on the other foot.

If anything, you, the Federal Government, the Medicare program is giving a subsidy to the very hospitals and HMO's we compete with, and it is about $800 per admission. So, rural hospitals are not here today or this year asking for subsidies. I think, if anything, we are asking Congress to question, more thoroughly, the subsidies that are currently being given to our competitors.

Admittedly, that is a more Wisconsin, non-frontier type of statement, but I think there are lots of hospitals around the country that are working at urban-rural county lines.

It is very clear to me that the prospective payment system did not conceptualize a reality where, within one competitive market, there would be both urban and rural communities. The whole system pretty well tends to assume that rurals are unto themselves in one community and that urban hospitals are competing with themselves in other.

There has been research funded by HCFA, the Health Care Financing Administration, that talks about not giving favors to traditionally high cost hospitals. Therefore, they wanted to get very quickly away from historical cost.

However, in fact, the whole system that we are dealing with today is continuing to carry forward the early 1980 historical cost differences. So, it is okay to create that level playing field within the arena of one urban area, but we still have that uneven playing field between urban and rural locations.

Some people may tell you that, well, the operating margins have converged between rural and urban sectors, and I think that is true, but I also think it is understandable in a number of different ways. I would contend that a lot of additional money has been pumped into the urban side of the equation at the same time we have been giving relatively less money on the rural side.

I think to say that equal operating margins means equity is as false as saying segregated school systems had equity because both black and white districts broke even at the end of the year. In my mind, there is absolutely a fair comparison between those two situations.

Urbans have had more money to play with, and rurals went into the system more lean and have had to get even more lean as they went along. So, the fact that on average we are still holding our heads above water (barely) is not a testament to the equity of the system.

One of the things the Rural Wisconsin Hospital Cooperative did do, which I believe is thought to be innovative, is that we created a rural based HMO. But we are competing against HMO's affiliated with those hospitals that are receiving those subsidies I mentioned, not exactly fair competition.

That $800 in admission means every time a rural resident is attracted out of our community into the urban area for primary hospital type services that we can offer that is $800 more the government pays, and it is $800 more that hospital and HMO complex have for recruitment for clinic subsidies to attract more rural folks into the urban area.

In Wisconsin, I think for a lot of reasons—primarily due to the innovations of the people I work for, the rural communities and rural hospitals, we have held our own market share. We have had a relatively stable division of people using local services and using urban services.

Our problem is not that rural people are voting with their feet and leaving us. They are staying with us. But even with their staying with us, we are not getting the type of reimbursement necessary.

Both the cooperative and the National Rural Health Association support the concept of one rate. It is not the concept that all hospitals should be paid exactly the same. What we are saying is where there is a difference, the burden of proof must be on the government, on the Administration, to show specific rural hospitals can do it more cheaply in a particular rural area.

At this point, we have lost contact with relevant comparisons both in time and specific geographic areas. We are thrown into pools that are both outdated and geographically too dispersed.

In summary, we need change. We need a lot of change. In the private sector, we ourselves are working with and for rural hospitals which have to change and are changing, but we also need a comparable amount of change in the public sector. I don't think we are going to be able to pull it off unless we get change in both sectors.

Thank you.

[The prepared statement of Mr. Size follows:]

THE RURAL WISCONSIN HOSPITAL COOPERATIVE, COOPERATING IN ORDER TO COMPETE

Testimony to the Senate Special Committee on Aging
June 13th, 1988

Tim Size, Executive Director
Rural Wisconsin Hospital Cooperative
Prairie du Sac, Wisconsin

Member of Board and
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National Rural Health Association
Kansas City, Missouri

Preface

Rural hospitals in Wisconsin have been searching for analternative to the two extremes of unsustainable traditional autonomy or "selling out" to other state or national corporations. As a result of that search, the Cooperative has had substantial growth since it was begun in 1979 as a regional shared service organization and advocate for rural interests.

In 1983, one of the nation's first rural-sponsored HMOs was licensed as a joint venture between local physicians and hospitals as the result of a Cooperative initiative. In 1985,the Cooperative was named the Outstanding Rural Health Program of the Year by the National Rural Health Association and was awarded a citation of merit by the Wisconsin Legislature. In 1987, it was recipient of a Robert Wood Johnson Foundation Hospital-Based Rural Health Program Grant Award.

The rural hospitals that are the Cooperative have no illusion about the difficult years ahead. They realize that not all will continue as acute care hospitals and that most will be substantially changed. The Cooperative is seen as having the potential to be the vehicle to develop an alternative and perhaps better system built on values consistent with local primary care and community controlled not-for-profit facilities. The future of these rural hospitals and communities lies in their own hands, not that of some distant forces.

Description of Area and People

RWHC Hospitals are located in 16 counties in southern and central Wisconsin (2 SMSA, 14 rural); of the 14 rural counties, 12 contain only RWHC hospitals. In those 12 counties where all of the county is in the RWHC service area we serve a population of 300,000 people spread over an area of 9,000 square miles with a population density of 32 people per square mile. Compared to neighboring urban counties, our population is in worse health, significantly older, poorer, more unemployed and working in declining industries.

In the 1980 census, individuals over 65 years of age represented 15.5% of the area's population, 129% of the state average. Medium family income in 1979 was $16,001, 76.5% of the state average. 9.5% of families were below poverty level, 151% worse than the state average. Unemployment (in 1986) was at 8.6%, 124% of the state average. Individuals in 1980 were primarily employed in services (23%), manufacturing (21%), agriculture (20%) and retail trade (14%). Compared to employment in the nearest urban counties, we were much more dependent on agriculture while much less involved with the service sector. RWHC hospitals employed 6.7% of the total of employed females in our service area.

RWHC Hospitals and Key Characteristics

RWHC consists of 19 rural acute general medical-surgical hospitals and the University of Wisconsin Hospital. The rural hospitals average 50 beds with an occupancy of 41%, 1549 admissions, 4227 emergency room visits, 9626 other outpatient visits, total hospital revenues of $4.6 million, total inpatient revenues of $3.3 million (53% Medicare, 7% Medicaid, 6% HMO, 5% Bad Debt/Charity Care). Nursing homes are run by 10 hospitals,averaging 75 beds at 89% occupancy.

What Can A Cooperative Do For A Hospital And Community?

This question is a little like asking if regular exercise will do you any good - it will, but only in proportion to what you put into it. We all know there is no free lunch, only ones that taste a little better for the price.

As the Cooperative doesn't offer loss leaders to capture patients or corporate buyouts to take over responsibility and assets, active membership in the Cooperative requires the rural hospital's personal involvement in the governance and continuing development of the Cooperative. This is the Cooperative's primary "charge" for facilitating a community's ability to sustain a local hospital.

Like exercise, the Cooperative doesn't pretend to have one approach for any and all situations - but it does hold for those willing to get involved with us the opportunity to build the local flexibility and united strength required by today's competitive health care environment.

Why and How Was the Cooperative Begun?

The Rural Wisconsin Hospital Cooperative was incorporated in the summer of 1979 following informal discussions among several hospital administrators in southern Wisconsin. The purpose was to develop a corporation that could be a base and catalyst for the development of joint ventures that was not controlled by any one hospital. The model of the dairy cooperative was chosen because it respected the autonomy of the sponsors and was a type of organization familiar to the community boards that would have to approve individual hospital participation.

A few early successes were seen as critical to establishing the credibility necessary to gain more substantive commitment from existing members as well as to attract additional members. During the fall of 1979, the decision was made that a paid staff person was necessary if the Cooperative was to develop as a serious enterprise. Consequently, each of the 10 members at that time pledged $5,000 for the first year (now $6,500 per year.) An Executive Director was recruited and office space found in one of the hospitals. The Cooperative, exclusive of affiliated corporations, currently employs about 40 people with an annual budget of $1,000,000.

At the same time, a second major function of the Cooperative was developed in response to a local health systems agency's committee report. Without input from the communities to be affected, a series of draft recommendations was released that suggested the consolidation or closure of most of the rural hospitals in southern Wisconsin. Public opposition was demonstrated by attendence in the hundreds at each of the hearings held around the region. The Cooperative led the charge (or was led by it) to successfully defeat an unfortunate example of top-down planning.

The Cooperative, at a very early point in its development, was given the opportunity to demonstrate the value of rural hospitals working together while simultaneously attracting substantial favorable public attention in many rural communities. The mission of the Cooperative being expanded beyond its initial one of shared services to include rural advocacy was made, not born.

Statement of Mission and Goals

In 1985, as part of the ongoing corporate planning process, the following was developed as an updated statement of Cooperative mission and goals. While it has the mandatory praise of motherhood, this statement clearly indicates a commitment to developing a more highly integrated system of rural health care.

"The Cooperative as hospitals acting together will promote the preservation and further development of a coordinated system of rural health care. Such a system will provide both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values. Through its collective strength, the Cooperative is a catalyst to create necessary change in the delivery of rural health care
The Cooperative recognizes it has an important role in rural economic development. To meet this mission, the following goals are established:"

"[The Environment] The Cooperative will utilize its collective strength to support rural health care and rural communities in both private and public sectors. It will represent the rural perspective on legislative and regulatory issues affecting rural health care and illness prevention with the political influence necessary to be an effective advocate. It will negotiate jointly, as appropriate, to maximize the effectiveness of its members in private sector affairs."

"[The Corporation] The Cooperative will develop alternatives for rural hospitals and affiliated institutions to the increasing presence of competing health care corporations and systems."

"[Products And Services] The Cooperative will develop and maintain efficiently operated services for its members. It will be a corporate vehicle to provide flexibility to individual institutions by incorporating a broader base of support for programs requiring substantial participation or risk sharing."

The Basic Cooperative Model

Each Cooperative hospital has one representative (usually the administrator) and vote on the Board of Directors. The officers initially acted as a steering committee. Each hospital agreed to be assessed an equal sum for overhead and development expenses
Membership was restricted to rural hospitals, with an exception made for the University of Wisconsin Hospital and Clinics given its participation in the initial development.

Participation in particular shared services has always been voluntary and on a contracted fee-for-service basis. Public statements by the Cooperative are usually only made about areas of clear consensus among the rural members.

After several years, the steering committee became an Executive Committee and was expanded to include the immediate past president and a member-at-large. Recently, as the business of the Cooperative has become more time-consuming, the Executive Committee has become increasingly involved in the overall direction of the Cooperative. However, all of the voting members acting as the Board of Directors continue to be the principle Cooperative authority.

The initial bylaws included two ideas that have not been implemented - to give additional votes to those members that bought more services and to create an Executive Board when the membership exceeded 16 members. The lack of interest to implement these two provisions probably reflects a degree of comfort with a sense of common bond between the hospitals and concern for losing control through the development of an elite inner group.

Reaction within the Hospital Community

The initial response to the development of the Cooperative appeared to be quite varied among the provider community in southern Wisconsin. Those rural hospitals participating felt a need for the organization and were cautiously optimistic about the Cooperative's long-range potential. Others were supportive but wanted to see how it did before joining or attempting to get their Board's support for general assessment. Several rural hospitals indicated that they had no interest in being part of the Cooperative because they did not believe in the concept or did not believe they would receive sufficient benefit to justify the participation. While, to date, the Cooperative has grown substantially, rural hospital opinion about the Cooperative appears to continue to fit into one of these categories.

The Cooperative by nature is a relatively open enterprise and has continued to try to attract and welcome new members interested in working to develop a rural hospital system. To the credit of the hospitals that led the early development, new members are not asked to "buy in" and reimburse for past investments. The existing members realize that it is through strength in numbers that they can balance other major forces.

The Cooperative was first seen by some in the Madison press as an outreach tool for the University - a mechanism for the University to use "its" Cooperative to steer patients towards its specialty services. Since then the independence of the Cooperative from any particular dominance has been demonstrated.

Among other urban hospitals, the practical implications of the Cooperative appear to have become clearer in terms of its roles as a potential competitor, ally and purchaser of service. The Cooperative's long-term prospects continue to be perceived as uncertain by some, particularly larger corporate interests that are the least comfortable with a model that is explicitly presented as an alternative to totally centralized control.

In general, physicians initially considered the Cooperative an administrative activity unrelated to their individual practices. Since its participation in the successful development of a health maintenance organization, HMO OF WISCONSIN, many rural physicians have expressed support for the Cooperative and appreciation for its early work. The HMO is notable for having brought physicians and hospitals to the same regional table to face their mutual threats and opportunities. Some urban physicians expressed discomfort with the Cooperative's role in assisting rural physicians to organize themselves independent from urban-based clinics and HMOs.

The initial reaction of the state hospital association was one of indifference given the original singular focus on shared services. Once the Cooperative became more visible politically and active as an advocate for rural interests, a natural concern and perhaps antagonism developed about the Cooperative. At worst, it was seen as having the potential to become an alternative trade association for rural hospitals or, at best, threatening the Association's effectiveness as the sole voice of hospitals with State government.

What has evolved is a good working relationship between the Cooperative and the Association similiar to that which the Association has had for years with a council of Milwaukee hospitals. None of the hospitals in the Cooperative has dropped their membership in the Association, and on many issues, the Cooperative has given the Association independent political support. The Cooperative has provided a partial outlet for the Hospital Association with issues that are inherently devisive for rural and urban members.

Shared Service Development

The difficulty of recruiting and retaining physical therapists was the specific problem that was the catalyst for the formation of the Cooperative. Appropriately, a Physical Therapy Service was the first shared service implemented by the Cooperative, in the spring of 1980. A Director was hired with the responsibility of recruiting and supervising other therapists while also individually providing direct service to reduce the overhead of developing the department.

While there is no easy answer in this area of relatively scarce personnel, a network approach has reduced duplicative efforts at recruitment and tended to reduce the isolation traditionally associated with rural placements. This model has been expanded to the areas of respiratory therapy, audiology and speech-language pathology services.

During the first year, it became clear that a major issue with the Cooperative would be the "outmigration" of patients from rural counties to urban medical centers. Available data indicated that a significant percentage of rural residents were not using their local providers for primary care. It was also clear that once they were in their car, they overwhelmingly drove a little farther to urban providers for that primary care. The myth of blind community loyalty was seen as just that. It was understood that the threat for rural providers was not their neighbors but the aspirations for expansion by many regional medical centers.

Then it was called outmigration; now it is called the results of competition. It was agreed that if the Cooperative was to prove relevant to rural hospitals, it would need to address this issue head-on. Since the early 1980's, the observed increases in outmigration of patients from the service area has stopped but how much is the result of Cooperative initiatives is unclear.

Also in our first year, a general dialogue was begun with the W. K. Kellogg Foundation which eventually led to a $150,000 grant being awarded in the fall of 1983. This, the Cooperative's first grant, was to fund the development of a cooperative infection control project that determined the most efficacious and necessary approaches to infection control in rural hospitals and nursing homes.

In 1980, a contract was made with a Madison-based legal firm to provide legal services to the Cooperative and interested Cooperative members. In addition to the financial benefits of contracting as a group for specialized health law and regulation expertise, there was the substantial advantage of having one firm in the state capital that would, over the next several years, gain an intimate understanding and focus on the reality of rural health care.

In 1980, the Cooperative Executive Director represented the member hospitals in a series of negotiations with several groups of pathologists that provided on-site consultation services and reference laboratory services. By a demonstrated willingness to work as a group, along with the Cooperative having advertised for staff pathologist(s), the hospitals were able to achieve more reasonable terms from their existing providers without changing individual sources of the service.

Since 1980, the Cooperative has continued to develop and in some cases "spun off" as separate corporations the following services as need and opportunity allowed; a current list includes:

- Audiology Services
- Continuing Education for Administrators
- Equipment Purchasing Clearing House
- Emergency Room Physician Coverage
- Financial Management Consultation
- Health Maintenance Organization
- Hospital Trustee Education
- Insurance, Health
- Legal Services
- Market Research
- Management Development/Guest Relations
- Middle Management Development
- Mobile CT Scanning
- Mobile Nuclear Medicine
- Patient Discharge Studies
- Physical Therapy
- Printing Services
- Respiratory Therapy
- Syndicated Advertising
- Utilization Review Consultation
- Speech-Language Pathology Service
- Quality Assurance Consultation

In addition to the above activities, the Cooperative staffs a large number of Subject or Profession Specific Task Forces among the hospital's professional staff and middle managers. Most meet quarterly to work on joint problem solving and to develop peer contacts for use between meetings; a current list includes:

Audiology Marketing
Community Health Education
Clinical Laboratory
Dietary
Financial Officers
Guest Relations
Hazardous & Infectious Waste
Management Development
Patient Business Managers
Personnel
Pharmacy
Physical Therapy
Purchasing
Radiology
Respiratory Therapy
Social Work
Surgical RNs
Utilization Review
Quality Assurance

The development of insurance programs through the formation of a Multiple Employer Trust and the development of HMO OF WISCONSIN will be discussed later in this paper.

Can The Cooperative Save Us Money?

This depends on the hospital, but most members save their annual assessments many times over - a pretty good and rare return on investment.

RWHC's primary commitment is to its owners, the member hospitals, as opposed to other economic or medical-political interests. Under the law governing cooperatives, excess proceeds can not be retained but must be returned to the Cooperative members.

Typical annual savings for those projects meant to reduce costs have been $30,000 on health insurance through the Trust and a simillar sum for renegotiation of certain hospital-based medical services. A group purchase of mammography equipment saved over $4,000 per unit. The capital worth of HMO OF WISCONSIN to each participating community hospital and medical staff is conservatively put at over $750,000.

Many of the Cooperative's shared service programs have enabled hospitals to provide high quality services previously unavailable or very difficult to recruit and/or retain staffing for. This has generated a substantial revenue for those hospitals purchasing services. The networking of staff within RWHC expands coverage opportunities and provides support for individual staff previously isolated in rural areas. Community residents are able to take advantage of services at the local hospital eliminating travel expense and inconvenience.

Summary of Shared Service Approaches

It has become clear that there were several different ways in which a Cooperative could function to create shared service opportunities for participating hospitals. The first and most obvious is the purchase and resale of a service such as the group purchase of legal services. [Given the availability in Wisconsin of strong group purchasing organizations for drugs and supplies, the Cooperative has not developed substantial activity in this traditional shared service area.]

A second method is the employment of staff by the Cooperative to provide specific clinical or administrative services, such as physical therapy or administration of the Trust. A third method is the use of Cooperative staff to act as an agent but non-contracting party for the hospitals, as in the case of the pathologist negotiations. A fourth method that will be noted later in this paper is the development of separate affiliated corporations, such as in the case of the HMO OF WISCONSIN. Obviously, several of these approaches may be applicable for any one project. Shared service programs have grown because services were designed that met the needs of significant numbers of hospitals at a competitive price and due to the commitment of the hospitals to invest in the Cooperative by purchasing its services.

In 1983, the administration and development of shared services grew to the point where a Director of Shared Services could be hired. As with all young corporations, the attraction of the right staff at the right time was critical. Individuals in a new business seem to thrive on ambiguity, long hours and some benign neglect. They appear to be driven less by current rewards or praise and more by the excitement of a vision of what can be and the satisfaction of having the opportunity of being part of a significant creative process.

A real benefit of the Cooperative from the staff's perspective is that the primary market for shared services is also the corporate board. Every board meeting is, in part, a focus group of representatives of the Cooperative's principle customers. An openness by board and staff has kept new service failures to a minimum, and problem areas of existing services are usually identified at an early stage.

A problem that has been experienced with the board being made up of hospital administrators is that individual hospital responsibilities can conflict with Cooperative board responsibilities - what is in the interest of the group as a whole versus the perceived interest of an individual hospital.

A less well-defined problem is the cultural differences between the hospital administrators on the board and the Cooperative staff. Understanding continues to have to be built between individuals working within the corporate culture of established hospitals and cooperative staff working within a multi-community corporation somewhat removed from local medical and community pressures.

The idea was developed that rural hospitals were not less important versions of large hospitals but, in fact, had an equally important but unique role in the health care system This was, and still is, an uncomfortable position for some rural hospitals because it is a position perceived as carrying with it the danger of being stigmatized as a lower class or lower quality hospital. The position of the Cooperative has always been that, while the rural hospital does not provide all services, what it does do, it can and must do well.

Rural hospitals have a natural advantage in the critical area of delivering accessible and personalized care compared to larger and necessarily more complex institutions. Personal and accessible care through rural hospitals is their competitive edge, a natural strength upon which specific shared services can be built.

Development of a Cooperative Multiple Employer Trust

In mid 1982, following the decision of the Federal Government not to fund an application to study the feasibility of a rural-based HMO, the Cooperative again addressed the issue of developing an alternative health-care plan. The context was one of rapidly escalating employee health insurance premiums, a lack of carrier explanation of those increases and a continued desire to find a mechanism to deal with the patient outmigration problem.

A local consultant familiar with both the insurance industry and health-care providers was engaged to facilitate our review of options. Bid specifications were drawn up and sent to major insurance agents and carriers active in Wisconsin. The response was not encouraging. Some companies doubted the Cooperative's ability to form a cohesive group for insurance purposes, others could not understand the need to develop a model that provided rural communities greater incentives to use local providers.

In the end, it became clear that the development of a Multiple Employer Trust with its own self-insured health benefit plan was at that time the principle option. The Trust was developed, and coverage began in August of 1983 for approximately 3,500 employees and dependents of 11 Cooperative hospitals. Benefits were kept comparable for most of the hospitals. Premium collection, cash management and coordination between the hospitals was the responsibility of the Cooperative; claims administration was subcontracted to a firm specializing in that service in Kansas City.

Approximately $350,000 in premium expenses was saved in the first year - a 16% reduction per hospital of what would have been paid to their existing carriers. These savings were in addition to the allocation of sufficient premium income in the first year to create the necessary reserves for claims that were incurred but not paid during that year. These reserves were distributed through a bid process to rural banks, thus contributing substantially to the investment capital available for other rural businesses. Given regulatory changes, the Trust is now converting its health benefit plan from self-funded to one that will be commercially underwritten.

Development of a Rural-Based HMO

While the Trust was being developed, it was understood that there was a high probability that eventually the Cooperative would have to come back to the need for a rural-based HMO. What was not anticipated was that in the spring of 1983, months before the Trust actually became operational, the HMO would be actively under development. While it was the environment, not the Trust, that led to the development of the HMO, the development experience gained by both the staff and the Board was good training for the HMO development process.

The Cooperative decided in 1983 that any possibility of an independent rural-based HMO had to be pursued at that point in time - that there was a window of opportunity that would quickly be lost once rural providers were divided up amongst the various urban-based plans. The decision was understood not to be whether HMOs were "good or bad," but whether individuals wanted to be part of their own or eventually reduced to being merely an agent or employee of HMOs controlled by competing specialty clinics or insurance carriers.

Two task forces were created, the first to focus on HMO administration and the second on medical components. The former evolved into HMO OF WISCONSIN, a licensed stock insurance company, and the latter into the Rural Physicians' Association, a for-profit corporation representing all physicians that provide services to the HMO.

The HMO is governed by a board comprised equally of a physician and hospital administrator from each sponsoring community. The RPA is governed by representatives of physicians that admit at least half of their patients to rural hospitals. The actuarial risk associated with any insurance plan is shared by both the hospital and physicians.

By the end of 1984, the HMO had attracted 8,500 members compared to the 3,500 budgeted. In mid-1986, the HMO has 30,000 members, close to 40 participating hospitals, 1,500 physicians and is active in over 20 rural counties. Medical care not available in rural communities is purchased through contract with participating medical centers and specialists. It currently offers both a high- and low-option benefit package for groups of 10 or more. Individual plans are available for dairy farmers - FARMCARE; a Medicare supplement package began to be offered early in 1985 - 65 PLUS.

Robert Wood Johnson Foundation Hospital-Based Rural Health Care Program

The Cooperative was awarded a grant of $341,000 for two years from the Robert Wood Johnson Foundation, the nation's largest health care philanthropy. The grant is one of 13 awarded under the foundation's Hospital-Based Rural Health Care Program.

Rural hospitals are facing a substantial number of critical challenges; three areas stood out as particularly critical and as having the greatest potential responsiveness to a cooperative approach: Quality of Care, Financial Management and Governance. Price Waterhouse has similiarly identified medical staff development strategies (quantity and quality), financial management and management/board direction as key concerns of successful rural hospitals.

The Robert Wood Johnson Foundation problem statements and program objectives are as follows:

Quality of Care

Problem: JCAH, private and government sectors are all shifting their focus to "did you make use of your capabilities and did you get good outcomes as the result of your actions?" (O'Leary, JCAH) According to Price Waterhouse, "...rural residents have demonstrated their willingness to drive to the city if they do not have confidence in local doctors."

Program Objectives: Improve Cooperative hospitals' quality of care through (1) administrative and technical support for existing hospital quality assurance programs, (2) the implementation of a cooperative quality assurance program and physician credentialling process.

Financial Management

Problem: "... many failed hospitals might have remained open if they had adhered to sound financial principles such as budgeting, cash flow analysis, sophisticated billing policies and procedures, product line analysis, cost accounting and risk management."

Program Objectives: Improve Cooperative hospitals' financial management by (1) assessing the "state of the art" of Cooperative hospital financial management and (2) providing inhouse consultation and ongoing educational/discussion roundtables of financial officers driven by annual needs assessments.

Governance

Problem: "Trustees and administrators of failing hospitals either do not have or fail to follow a relevant long-range plan. They lack meaningful policies and procedures for operations, and measureable objectives with appropriate feedback."

Program Objective: Improve Cooperative hospitals' board governance through (1) formal director recruitment programs, (2) local educational sessions and regional educational/discussion roundtables and (3) introducing meaningful board evaluations.

Advocacy for the Rural Reality

During its first year, in part due to the controversy about closing rural hospitals, the Executive Director was asked to become a member of the Board of the Regional Health Systems Agency. Since then, the Cooperative has represented a rural community perspective to the Department of Health and Social Services (Health Planning, Medicaid), Office of the Commissioner of Insurance (HMOs), Hospital Rate-Setting Commission (agency now discontinued) as well as to the legislature as a whole.

Again, these activities do not replace the state hospital association that frequently speaks on behalf of its rural constituency, but is, in effect, a supplement to that effort.

Advocacy within an industry as important as health care is not limited to formal governmental units. Examples of primary linkages that have been maintained by the Cooperative are as follows:

- o Wisconsin Association of HMOs
- o Wisconsin Association of Manufacturers and Commerce
- o Wisconsin Federation of Cooperatives
- o Wisconsin Hospital Association
- o Catholic Health Association Of Wisconsin
- o State Medical Society of Wisconsin
- o Health Planning Council, Inc
- o Southern Wisconsin EMS Council
- o Wisconsin Health Facilities Authority
- o UW-Madison Med Flight Advisory Committee
- o UW-Madison Health Services Administration Program
- o Shared Magnetic Resonance Imaging Facility, Inc
- o Center for Public Representation
- o Coalition of Wisconsin Aging Groups

What are the attributes of rural hospitals and communities that need to be considered when health-care policy is being developed - both at the point of problem definition as well as proposed resolution? The following specific factors comparing most rural hospitals to many larger urban-based facilities have been noted over the last 6 years of Cooperative activity. Organizational Factors:

- o fewer on-site administrative resources
- o greater control by Board
- o higher visibility/accountability in community
- o larger daily fluctuation in demand for services
- o fewer cash reserves to absorb major changes
- o lower Medicare reimbursement for same service
- o greater Medicare domination of budget decisions
- o greater Medicare cost-shift per private payor
- o more difficulties in recruiting basic specialized skills
- o greater dependency on individual physician activity
- o closer hospital-physician relationships.

Community Factors:

- o higher, if not double, unemployment rates
- o lower (80% to 90%) family incomes
- o fewer options for medical care within area
- o not multiple hospital communities
- o larger share of local employment opportunity
- o greater importance as part of community pride
- o greater importance as part of keeping or maintaining businesses
- o less diversified and thus more vulnerable local economy.

A Rural Hospital's View Of Medicare

There is a paradox in the relative power of rural hospitals. On one hand rural hospitals are part of a powerful industry while on the other, most struggle with an uncertain future. Within that industry, the average rural hospital is in a minority position given the geographic and demographic uniqueness of its service area as well as the inadequate resources available to both the hospital and community.

The Medicare Prospective Payment System (PPS) (hospital payments based on DRGs) was sold to Congress as a fair way to control hospital costs and maintain local access to quality health care. But according to the Prospective Payment Commission, 47% of rural hospitals (in PPS Year 3) experienced a Medicare deficit in their PPS Payments, twice the rate of urban hospitals.

It is no mystery why half of rural hospitals are currently not even recovering their costs. As a result of HCFA's formulas, urban hospitals are paid on average nationally for the same discharge 37% more than rural hospitals. For example, a rural hospital outside of Madison, Wisconsin will be paid a base rate of about $5800 for a hip replacement or $1,900 less than an urban hospital across the Wisconsin River would be paid for treating the same patient!

Rural hospitals are particularly vulnerable to any underpayment by Medicare - as small businesses with minimal reserves, historically low operating margins and relatively little private income, they have no cushion to absorb large government induced losses. As nearly half of the patients admitted to rural hospitals are beneficiaries of the Medicare program, its policies have a disproportionate impact on rural communities.

During times of economic downturn and change there are closures of marginal facilities but if Medicare's reimbursement formula is not changed in the near future, it in combination with an increasingly competitive environment will force the closure of many well-run and needed rural community hospitals.

Many rural communities compete head-to-head with urban communities to attract Medicare patients. The Government is currently paying urban facilities a substantial premium for each additional admission from rural counties, allowing these facilities to increase their portion of rural "markets" by financing urban outreach, advertising, buying of rural clinics, the "forgiving" of Medicare deductibles, underwriting competing HMO insurance premiums ("non-risk" types), and other competitive practices.

The lower payments to hospitals on the rural side of an urban county line are costing rural communities many hundreds of thousands of dollars per year in lower wages and fewer jobs. Rural communities, already hard hit by agricultural and other economic losses, can ill afford the loss of another major source of jobs and income. Beyond the impact on access to local health, the loss of local medical care would have a direct and indirect loss to a typical rural community's economy of over 10 million dollars per year. With less money in local circulation, more jobs will be lost throughout the community and those remaining residents will incur higher local property taxes.

While the Government pays urban hospitals bonuses to recruit Medicare patients from rural communities, it says rural health care is substantially less expensive. The closing down of rural health care makes for more expensive healthcare nationally while further depressing the rural economy; both expand the Federal spending by increasing charges to Medicare and demands on social welfare programs.

Rural physicians are also subject to substantial discrimination, receiving substantially less payment for treating the same illness out of a rural, rather than an urban office. This Federal policy obviously makes attracting and keeping physicians in rural communities unjustly difficult. The dramatic January 1st dumping of 26,000 Medicare beneficiaries from Minnesota HMOs with "risk contracts" is directly attributable to the combined impact of the discriminatory payments against rural hospitals and physicians.

Just as Federal income tax rates and social security tax rates are no lower in rural communities; the same should be true for payments for health care. The Government should pay for the same level of service without discriminating against people because of where they live and work. Health care services, rural and urban alike, should receive the same level of Federal support when the same service is provided. Will the Federal Government start paying less to social security beneficiares who live in rural counties? Do they pay less to Federal employees in rural areas? Do rural manufacturing contractors to the Federal Government have discounts applied against their bids?

For those of us outside of Washington, Federal budget negotiations are hard to follow, but rural hospitals were encouraged to see a higher rural Medicare update approved by Congress last winter. Rural hospitals understand the financial squeeze on the Federal Budget but they also understand that changes in payment distribution among hospital providers can be largely done in a budget neutral manner. Recent changes constitute real progress, but given a 37 percent differential, we must go a lot farther before saying the problem is resolved.

Clarification Of The Rural/Urban Medicare Payment Differential

Frequently, the disagreement over the amount of the rural/urban differential has gotten in the way of a reasonable discussion about what should be done about it. In short, there has been some confusion about the "real difference" in rural and urban payments; with these paragraphs it is hoped the issue can be put to rest.

Useful ways of presenting the range of urban/rural payment differences (urban as a percent greater than rural) include (1) the difference in the published National Rates unadjusted for wage or case mix variance, (2) the difference in the National Rates adjusted by an average area wage index but unadjusted for case mix variance and (3) the difference in the National Rates adjusted by an average Area Wage Index and an average Case-Mix Index. We understand the actual difference for the period 4/1/88 - 9/30/88 for each definition to be as follows:

(1) 14.5% = Difference in the published National Rates;
unadjusted for Wage or Case Mix Variance.

(2) 36.8% = Difference in the National Rates;
adjusted by an average Area Wage Index.

(3) 56.8% = Difference in the National Rates;
adjusted by an average Area Wage Index
and by an average Case-Mix Index.

It is our contention that for general purposes, definition (1) understates the difference and definition (3) overstates it. Definition (2) allows you to focus on what people are on average actually receiving for the same service. The use of definition (2) allows people to raise the issue that a major share of the payment inequity is based on issues related to the appropriateness of the wage adjustment to individual rural hospitals and to rural hospitals as a whole.

The Health Care Financing Administration's View Of Medicare Inequities

What is HCFA's perspective? Last summer, several pounds of a draft "Report to Congress on Urban/Rural and Related Geographical Adjustments in the Medicare Prospective Payment System," were circulated (three years over due and still not released).

HCFA briefly noted a number of critical assumptions but it seems that readers are expected to focus on the report's "findings" without stopping to question the reasonableness of the assumptions upon which they are based. One of their major stated assumptions is that a 'fair system' is one that yields similar operating margins for different types of hospitals.

HCFA's summary stated that "simulated Medicare operating margins imply that changes made in 1986 will correct a systematic payment bias against rural hospitals and that "research will continue on refinements of the wage index for rural areas, but no clear improvement over the current index is available at this time."

Two findings not in the HCFA summary but in the body of the report are of significant interest. First, "if a major difference in casemix severity exists across urban and rural hospitals as a whole, this study was unable to document it with a broad set of measures readily available from claims data. In summary, there is very little evidence to indicate that, after controlling for differences in area wages and DRG case mix, urban-rural cost differences are attributable to a gross error in the measurement of case mix severity". Second, "physicians in urban hospitals practice a more technology-intensive style of practice that is unexplained by the mix of cases by DRG or severity of illness
Also, there is a strong correlation between procedure intensity and the size of the hospital."

HCFA stated that "simply eliminating the urban-rural rate differential would not be appropriate, since it would generate windfall gains or losses based primarily on systematic differences in practice intensity. One national rate implies one national norm of care ... (rural hospitals)...would acquire technologies and expertise needed to provide a wider array of services, and adopt the practice patterns of large, teaching hospitals practicing state-of-the -art medicine." These statements lend considerable credibility to those who see a clear extracongressional policy initiative to use PPS as a means to relegate rural health care to a permanent backwater position.

HCFA's statements can be reasonably interpreted as saying that they are either overpaying urban hospitals due to the resource intensive practice patterns of urban physicians or locking rural communities into only being able to support practise patterns that are inappropriately conservative.

A Rural Hospital's View Of HCFA's Medicare Position

The objection to the assumption that equal operating margins imply equity is at the heart of what many consider discriminatory about the entire Prospective Payment System. It is the same thing as saying that a segregated educational system makes fair payments to its schools if a black school receives less money than a white school but both break even at year end. Whether or not rural hospitals are being fairly paid, they can't spend money they don't have - operating margins are inherently of extremely limited usefulness when addressing equity issues.

HCFA has projected operating margins by basing operating costs on base costs increased by changes in input costs - apparently ignoring at a minimum both intensity and volume adjustments, volume changes that have been particularly significant for rural hospitals during this period. This approach conveniently inflates operating margins and sets the stage for saying the rural/urban problem has been resolved.

HCFA continues to assume that all types of hospital employees are recuited from the same hospital specific labor market - anyone who has tryed to recruit professional staff to a rural facility knows the reality is quite different. HCFA is still looking for a single labor market per hospital approach and rural hospitals know that it simply doesn't exist.

HCFA repeatedly stated: "All things considered, the principle argument against retaining hospital specific rates (within one community) is that varying payment rates among hospitals in a single locality would be perpetuated, thereby providing a competitive advantage to hospitals with higher historical costs, regardless of the reason for higher costs."

This is exactly what rural hospitals have been saying is a key problem. HCFA argues for not retaining any hospital specific rates but appears to have a "mental block" against seeing how the same argument applys equally well to not retaining the rural/urban rate differential within a given competitive market.

The Cooperative and National Rural Health Association Position

Most rural hospitals are not asking for the total elimination of any and all cost differentials between rural and urban hospitals. But they want any variation from a single rate to be the result of exogenous variables that are clearly demonstrated as being current and relevant to their particular hospital.

Many hospitals, urban and rural alike, believe that the problem rural hospitals are facing requires more than incremental change. Such change requires an active minority with a real passion about the future of rural health and rural communities.

Current Status and the Future

It is understood that the Cooperative is just the beginning of a process of debate and conflict. It is understood that any achievements that might have occured are not end points but part of a necessary long term development of even more significant cooperation.

It is hoped that rural providers can forge the necessary cohesion to survive and prosper during an era marked by increased urban competition and reduced government funding.

The spirit of rugged individualism continues fiercely in many rural communities and along with "high school sports rivalries" too frequently prevents neighboring communities from seeing the need to join forces for their mutual benefit. Many associated with the Cooperative believe that rural providers and communities can succeed if they decide to do so.

They must be willing to study their communities and determine what it is they want in their health care and then organize to provide it. The myth of undying loyalty by the local resident irregardless of the service or cost must be put to its final resting place. Rural communities need to recognize those with whom they share common interests and values and then work together to build a better health-care system consistent with those values.

We must see substantive changes in both Federal policy and private behavior in order to secure a stable future for rural health care.

{Portions of this testimony have been previously published by the National Rural Health Association and the American Hospital Association.}

The CHAIRMAN. Thank you, Mr. Size.

I am going to read one section of your testimony, because I think it is instructive, and I read it for purposes of emphasizing how instructive it is. On page 16 of your testimony, it is headed "A Rural Hospital's View of HCFA's Medicare Position."

"The objection to the assumption that equal operating margins imply equity is at the heart of what many consider discriminatory about the entire Prospective Payment System. It is the same thing as saying that a segregated educational system makes fair payments to its schools if a black school receives less money than a white school but both break even at year end. Whether or not rural hospitals are being fairly paid, they can't spend money they don't have—operating margins are inherently of extremely limited usefulness when addressing equity issues.

"HCFA has projected operating margins by basing operating costs on base costs increased by changes in input costs—apparently ignoring, at a minimum, both intensity and volume adjustments, volume changes that have been particularly significant for rural hospitals during this period. This approach conveniently inflates operating margins and sets the stage for saying the rural/urban problem has been resolved.

"HCFA continues to assume that all types of hospital employees are recruited from the same hospital specific labor market. Anyone who has tried to recruit professional staff to a rural facility knows the reality is quite different. HCFA is still looking for a single labor market per hospital approach, and rural hospitals know that it simply doesn't exist.

"HCFA repeatedly stated: 'All things considered, the principal argument against retaining hospital specific rates (within one community) is that varying payment rates among hospitals in a single locality would be perpetuated, thereby providing a competitive advantage to hospitals with higher historical costs, regardless of the reason for higher costs.' "

End of the quote of HCFA's statement. I continue:

"This is exactly what rural hospitals have been saying is a key problem. HCFA argues for not retaining any hospital specific rates but appears to have a mental block against seeing how the same argument applies equally well to not retaining the rural/urban rate differential within a given competitive market."

Now, Mr. Size, you have stated two or three times that the differential in Medicare payments between rural and urban hospitals is $800 per admission. On what do you base that?

Mr. SIZE. My basis for that would be for obviously an average type admission, I think something more around the areas of a DRG equal to 1. I was using wage adjustments in the Wisconsin sector which are a little better than the national average but still typical.

It includes both the difference in standardized rates and wage index adjustments.

It would not include the greater capital payments and educational adjustments and disproportionate share adjustments which, by and large, rural hospitals are barred from achieving. So, it is kind of a rough rule of thumb. It could be $700 or it could be $900. It depends on the specific assumptions you put into it.

The CHAIRMAN. In other words, you will hang your hat on that figure. Is that right?

Mr. SIZE. I think it is a good working figure, yes.

The CHAIRMAN. It is a startling figure to me. A differential of $800 per admission between the rural hospital and the urban hospital says something to me on why those statistics are stacking up the way they are—83 percent of the hospitals that have lost money under Medicare are rural hospitals. And, why the closures of rural hospitals are high compared to urban hospitals that are closing.

An earlier witness said that, indeed, rural hospitals are facing a catastrophic problem. I don't think that statement was blown out of proportion. I think it appears to be a proper statement, and I think we are getting down to the nub of where the problem is. An $800 per admission differential is indeed not just startling; it puts rural hospitals in a position of just gradual diminishing and results in closures that put patients in that area at a disadvantage in terms of availability of health care services. We are extremely concerned that this could have a terrible adverse effect on older Americans in rural areas.

Thank you very much for your testimony.

Senator Burdick.

Senator BURDICK. Mr. Size, how much of the financial problems now faced by rural hospitals can be attributed to the PPS inequities?

Mr. SIZE. I don't have an exact answer for that. I think my written testimony worked to balance responsibility of rural hospitals and rural communities to deal with creating more efficient hospitals with better linkages. So, clearly, some of that responsibility, if not a good deal of that responsibility, is ours.

But the Federal Government bears a major responsibility for the problem. The problem is a differential between a rural county in Wisconsin to a neighboring urban county is still 36 percent. The problem is cumulative urban operating margins in Wisconsin of over 40 percent in the first three years of PPS while it was only 16 percent in rural hospitals.

When you are looking at half the rural hospitals in this country losing money on Medicare in the third year of PPS, there is clearly a Federal problem. I can't tell you exactly how much of our problems can be attributed to PPS inequities, only that a great deal of it is the result of these inequities.

Senator BURDICK. If we eliminated the urban-rural differential, do you think that would take care of the problem?

Mr. SIZE. I think that is a major piece of the change that is necessary. I for one feel there are perhaps certain elements of the prospective payment system that fairly would create some differential payment between urban and rural. I think, though, the research indicates that it is a relatively small amount.

People talk about differentials being justified by severity of illness differences. I think most of the researchers I have read indicate that this is not true, or only to a limited extent.

If we had roughly equivalent Medicare payments, most of those rural hospitals that don't survive would not survive as a result of their own inefficiencies or a lack of local community support.

Perhaps in certain cases, in more isolated cases, there is going to be need for a subsidy, perhaps largely from that local community. But I think at this point, there is a very bad message being sent to us from Washington.

What Congress or HCFA is doing is teaching many of us around the country that equity isn't something that applies to us. The credibility of the government, the credibility of the Medicare program is in large measure on the mind and in the hearts of many of us, and I realize it is easier to say that than it is to fix it, but we are talking about the relationship between a people and their government, a sense of fairness.

Right now, that sense of fairness is really trampled, but I think if you talk about reducing that differential, you are going a long way to fine tuning the system and restoring our confidence in the Federal system.

Senator **Burdick**. Thank you.

The **Chairman**. Thank you very much, Mr. Size.

Our next and last witness is Dr. C. Ross Anthony, the Associate Administrator for Program Development at HCFA.

Please proceed, Dr. Anthony.

STATEMENT OF C. ROSS ANTHONY, PH.D., ASSOCIATE ADMINISTRATOR FOR PROGRAM DEVELOPMENT, HEALTH CARE FINANCING ADMINISTRATION

Mr. **Anthony**. Thank you, sir.

I am Ross Anthony. I am the Associate Administrator for Program Development at HCFA, and I am pleased to be here today to discuss the status of rural hospitals under Medicare with you.

I would like to summarize my statement that has been submitted for the record. Actually, I think I will take more time than I might otherwise just to go over this in detail seeing as how it does, I think, at least lend a different perspective than some of the witnesses you have heard earlier. That primarily, I think, comes from having to look at the system as an overall whole, not just looking at an individual hospital situation here or there, and it is that kind of perspective, I think, that is at least important so that we can gain a full understanding of what we and you, I know, think is an important problem that we all must be concerned with.

Mr. Chairman, the Administration shares your concern about access to care in rural areas and the future of rural hospitals. We have moved steadily over the past two years to improve and evaluate the financial status of rural hospitals under the Medicare program.

Today, I would like to share with you some of the initiatives we have undertaken or supported to provide more equitable treatment of rural hospitals under the Prospective Payment System.

Our actions have been guided by the following principles:

We are committed to fair and equitable Medicare payments for efficient hospitals.

Second, we are committed to ensuring access to quality care for all Medicare beneficiaries.

Third, we believe that hospitals should be subject to market forces and that the Medicare program should not be used to solve all the problems faced by rural hospitals, including maintaining of access to hospital care.

Under the PPS system, hospitals receive a predetermined payment based upon the diagnosis of the patient. If a hospital treats a patient for less than the PPS amount, it keeps the savings. If a treatment costs more, the hospital must absorb the difference.

Separate payments amounts were established by Congress for urban and rural hospitals to reflect the differing financial circumstances of their geographic locations. Since rural hospitals generally have lower costs and less complex cases, rural payment rates are lower than urban payment rates.

There are two areas of equity which encompass most rural hospital concerns and which you have heard addressed today. I would like to discuss both. First is the idea of horizontal equity or equal treatment of hospitals and second is adequate overall payment to meet hospital costs.

Addressing the first one, as part of our ongoing assessment of the impact of PPS on hospitals, we evaluate their Medicare profit margins. We have profit margin data available from the first three years of hospital performance under PPS, fiscal years 1984 through 1986.

In the first two years of PPS, rural hospitals did quite well financially with overall average profit margins of over 8 percent. However, these margins were half those of urban hospitals.

In the third year of PPS, Medicare profit margins for all hospitals declined. The average Medicare profit margins for all rural hospitals dropped to only 2.6 percent and almost half of the rural hospitals had negative margins. As in previous years, rural hospitals had substantially lower margins than their urban counterparts, who had 10.6 percent margins.

Recent legislative changes in the PPS rates provide for more equitable treatment of rural hospitals. Our analysis indicates that these changes will eliminate the disparity in profit margins that rural hospitals are able to achieve relative to urban hospitals.

If hospitals had been paid during the third year of PPS under today's rules, our analysis indicates that rural hospitals' Medicare profit margins would have been substantially higher and comparable to the average Medicare profit margin for urban hospitals.

Moreover, the percentage of rural hospitals with negative operating margins would have been comparable to the urban percentage. This has resulted primarily from a good number of statutory changes which I think you are well aware of, including separate reductions for outlier payments and higher rural hospital updates.

There are other things that need to be done, however, such as looking at different outlier thresholds which we could talk about.

I think you should realize that although we may have leveled the playing field for rural hospitals relative to urban hospitals—and we believe the payment differentials that remain are largely reflective of the differences in costs of care between urban and rural hospitals—the rural hospitals are not likely to be happy just because the playing field is level. In a sense, the playing field is now level, but the level is lower than it was before. This has caused financial distress, and many of the comments that you have heard today reflect that.

Although we believe that the current PPS rates as well as the fiscal year 1989 updates established in OBRA 87 are adequate for an efficient hospital, it is also important to realize that the overall average Medicare profit margins for all hospitals have fallen from the high levels of the first few years of PPS. We in the Administration and you in Congress must be vigilant to continue to establish payment rates that assure access to high quality care but also provide incentives for efficient operation.

This concern, I would only point out, is a concern of all hospitals and not just rural hospitals.

It is important to keep in mind that the financial pressures experienced by rural hospitals cannot and should not be seen as an exclusively or even primarily Medicare problem. Many factors have contributed to the plight of rural hospitals, including, at least:

Recession in the agricultural and timber economies,

Declining populations in rural areas, and rural residents seeking care at urban hospitals.

We believe that our payment rates should be equitable but that Medicare should not be used as a subsidy to ensure the solvency of all rural hospitals. Frankly, there are rural hospitals with occupancy rates of 10 to 20 percent that have not met the market test because people have decided [and sensed with their feet] to use other modes of care.

Declining occupancy in many rural hospitals has made it difficult, if not impossible in some instances, to provide sufficient community support to maintain a full service, high quality hospital. We need to consider alternative health care delivery systems to maintain adequate access to necessary care for Medicare and other beneficiaries in rural areas.

This may involve regional solutions such as establishing innovative primary and emergency care systems in certain rural areas with agreements to provide secondary and tertiary care when that is needed. It certainly will involve working in concert with State and local governments since they understand the unique problems of their own areas.

You have heard a little bit today about the Montana Medical Assistance Facility program. I am pleased to be able to announce that last week, we decided to fund this promising alternative, and a four-year demonstration project will now begin. We have funded, in a sense, a year to help design the project before we go forward finally with the waivers. We are pleased to fund the project and we believe that this is one type of innovative care that could in fact give us a solution for the future.

PPS contains specific provisions designed also to ensure beneficiaries have adequate access to care in rural areas. Special protections are afforded, for instance, to sole community hospitals, hospitals that are isolated from other hospitals by distance, geographic location, or weather and represent the sole source of care reasonably available in a geographic area.

Despite these protections, our analysis indicates that sole community hospitals have substantially lower profit margins than almost all other classes of hospitals. In a sense, the group of hospitals that we want to ensure is there to provide access is doing worse than many others.

In 1986, the profit margin for sole community hospitals was 1.57 percent compared to the national average of 8.93 percent. If current payment rules had applied, profit margins would still have been about half the national average. We are concerned that sole community hospitals may not be adequately protected by the current payment provisions, and we are assessing whether modifications to the system are needed.

Special payment considerations are also afforded to rural referral centers. In general, rural referral centers are large rural hospitals that serve as tertiary care centers and are paid at the urban rate.

Our data show that rural referral centers whose costs are higher than other rural hospitals but lower than urban hospitals had a Medicare profit margin of 7.8 percent in 1986. If current payment rules applied, the Medicare profit margin would have been among the highest of any class of hospitals. We are evaluating whether, in view of the OBRA changes, modification in the rural referral center policy also should be considered.

Let me go through a few other areas we deal with.

Since the inception of the PPS system, a significant portion of HCFA's research effort has been devoted to the analysis of the effect of PPS on rural hospitals. Much of this information has provided the basis for legislation that you have passed to change PPS policies.

Reports to the Congress that have been released in the last six months alone include special studies dealing with the urban-rural payment issues, sole community hospitals, rural referral centers, the rural hospital swing bed program, and the impact of outlier and transfer policies on rural hospitals.

I would like to make a plea that we continue to gather that necessary data and information, because, without that, you in Congress and we in the Administration will not have the data and information upon which to fully analyze these problems and make good policy decisions.

Let me list a few other of the many activities that we have ongoing in the department for you.

In research, we have begun an aggressive program that will result in a Federal Register solicitation this year aggressively soliciting rural health research programs. We have provided special seminars in areas like Kansas City to try to solicit good high quality projects.

We are moving quickly to comply with the law passed last year to set aside 10 percent of our research funds for rural projects.

The Office of Rural Health Policy which was passed into law last year has also been established, and we in HCFA are working very closely with them to be sure that the concerns and the effects of policy changes on rural hospitals are clearly understood.

Finally, the Secretary created a Rural Health Advisory Committee of prominent experts in the field who will be meeting soon to further discuss these issues.

In conclusion, I want to emphasize that the Medicare program is committed to making fair payments to all hospitals for care provided to Medicare beneficiaries, regardless of their location. Implementation of recent statutory changes will provide a better balance in the payments to urban and rural hospitals but will not eliminate either economic or non-Medicare related problems experienced by rural hospitals.

Furthermore, we and Congress must maintain our vigilance to be certain overall payment rates for all hospitals are adequate but also established in a manner that maintains incentives for increased efficiency.

Finally, let me assure you that we will continue our efforts to better understand rural problems and the needs and to find better ways to make equitable and appropriate Medicare payments to all hospitals.

Thank you.

[The prepared statement of Mr. Anthony follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF
C. ROSS ANTHONY, PH.D.
ASSOCIATE ADMINISTRATOR FOR PROGRAM DEVELOPMENT
HEALTH CARE FINANCING ADMINISTRATION
BEFORE THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
JUNE 13, 1988

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:
I AM C. ROSS ANTHONY, PH.D., ASSOCIATE ADMINISTRATOR FOR PROGRAM DEVELOPMENT OF THE HEALTH CARE FINANCING ADMINISTRATION. I AM PLEASED TO BE HERE TODAY TO DISCUSS THE STATUS OF RURAL HOSPITALS UNDER MEDICARE.

MR. CHAIRMAN, THE ADMINISTRATION SHARES YOUR CONCERN ABOUT ACCESS TO CARE IN RURAL AREAS AND THE FUTURE OF RURAL HOSPITALS. WE HAVE MOVED STEADILY OVER THE PAST TWO YEARS TO IMPROVE AND EVALUATE THE FINANCIAL STATUS OF RURAL HOSPITALS UNDER THE MEDICARE PROGRAM. TODAY I WOULD LIKE TO SHARE WITH YOU SOME OF THE INITIATIVES WE HAVE UNDERTAKEN OR SUPPORTED TO PROVIDE FOR MORE EQUITABLE TREATMENT OF RURAL HOSPITALS UNDER THE PROSPECTIVE PAYMENT SYSTEM.

OUR ACTIONS HAVE BEEN GUIDED BY THE FOLLOWING PRINCIPLES:

- WE ARE COMMITTED TO FAIR AND EQUITABLE MEDICARE PAYMENTS FOR EFFICIENT HOSPITALS,
- WE ARE COMMITTED TO ASSURING ACCESS TO QUALITY CARE FOR MEDICARE BENEFICIARIES,

- O WE BELIEVE THAT HOSPITALS SHOULD BE SUBJECT TO MARKET FORCES AND THAT THE MEDICARE PROGRAM SHOULD NOT BE USED TO SOLVE ALL THE PROBLEMS FACED BY RURAL HOSPITALS, AND
- O THAT MEDICARE SHOULD NOT BE THE EXCLUSIVE SOURCE OF FUNDING TO MAINTAIN ACCESS TO HOSPITAL CARE IN RURAL AREAS.

FAIR AND EQUITABLE PAYMENT

UNDER PPS, HOSPITALS RECEIVE A PREDETERMINED PAYMENT BASED ON DIAGNOSIS FOR THE CARE OF A MEDICARE PATIENT. IF A HOSPITAL TREATS A PATIENT FOR LESS THAN THE PPS AMOUNT, IT KEEPS THE SAVINGS. IF THE TREATMENT COSTS MORE, THE HOSPITAL MUST ABSORB THE DIFFERENCE. SEPARATE PAYMENT AMOUNTS WERE ESTABLISHED BY CONGRESS FOR URBAN AND RURAL HOSPITALS TO REFLECT THE DIFFERING FINANCIAL CIRCUMSTANCES OF THEIR GEOGRAPHICAL LOCATIONS. SINCE RURAL HOSPITALS GENERALLY HAVE LOWER COSTS AND LESS COMPLEX CASES, RURAL PAYMENT RATES ARE LOWER THAN URBAN PAYMENT RATES.

THERE ARE TWO AREAS OF EQUITY TO WHICH MOST RURAL HOSPITAL CONCERNS HAVE BEEN ADDRESSED THAT I WOULD LIKE TO DISCUSS:
1) HORIZONTAL EQUITY OR EQUAL TREATMENT FOR RURAL HOSPITALS, AND
2) ADEQUATE OVERALL PAYMENTS TO MEET HOSPITAL COSTS.

AS PART OF OUR ON-GOING ASSESSMENT OF THE IMPACT OF PPS ON HOSPITALS, WE EVALUATE THEIR MEDICARE PROFIT MARGINS. PROFIT MARGINS ARE MEDICARE INPATIENT REVENUES LESS MEDICARE OPERATING EXPENSES - EXPRESSED AS A PERCENTAGE OF MEDICARE REVENUES. WE HAVE PROFIT MARGIN DATA AVAILABLE FROM THE FIRST THREE YEARS (FY 84 - FY 86) OF HOSPITAL PERFORMANCE UNDER PPS. IN THE FIRST TWO YEARS OF PPS, RURAL HOSPITALS DID QUITE WELL FINANCIALLY WITH OVERALL AVERAGE MEDICARE PROFIT MARGINS OF OVER 8 PERCENT. HOWEVER, THESE MARGINS WERE HALF THOSE OF URBAN HOSPITALS. IN THE THIRD YEAR OF PPS, MEDICARE PROFIT MARGINS FOR ALL HOSPITALS DECLINED. THE AVERAGE MEDICARE PROFIT MARGINS FOR ALL RURAL HOSPITALS DROPPED TO 2.6 PERCENT AND ALMOST HALF OF THE RURAL HOSPITALS HAD NEGATIVE MARGINS. AS IN PREVIOUS YEARS, RURAL HOSPITALS HAD SUBSTANTIALLY LOWER MARGINS THAN THEIR URBAN COUNTERPARTS (10.3 PERCENT).

RECENT LEGISLATIVE CHANGES IN PPS RATES PROVIDE FOR MORE EQUITABLE TREATMENT OF RURAL HOSPITALS UNDER PPS. OUR ANALYSIS INDICATES THESE CHANGES WILL ELIMINATE THE DISPARITY IN PROFIT MARGINS THAT RURAL HOSPITALS ARE ABLE TO ACHIEVE RELATIVE TO

URBAN HOSPITALS. IF HOSPITALS HAD BEEN PAID DURING THE THIRD YEAR OF PPS BY TODAY'S RULES, OUR ANALYSES INDICATE RURAL HOSPITALS' MEDICARE PROFIT MARGINS WOULD HAVE BEEN SUBSTANTIALLY HIGHER AND COMPARABLE TO THE AVERAGE MEDICARE PROFIT MARGIN FOR URBAN HOSPITALS. MOREOVER, THE PERCENTAGE OF RURAL HOSPITALS WITH NEGATIVE MEDICARE OPERATING MARGINS WOULD HAVE BEEN COMPARABLE TO THE URBAN PERCENTAGE. THIS HAS RESULTED PRIMARILY FROM THE FOLLOWING STATUTORY CHANGES.

- O OBRA 86 IMPROVED THE WAY PAYMENT RATES ARE CALCULATED AND CREATED SEPARATE POOLS FROM WHICH TO PAY URBAN AND RURAL HOSPITALS FOR OUTLIERS - OR THOSE CASES THAT ARE EXTREMELY COSTLY OR INVOLVE UNUSUALLY LONG STAYS. URBAN HOSPITALS, HAVING MORE OUTLIERS, ARE REQUIRED TO CONTRIBUTE LARGER AMOUNTS TO THE POOL, WHILE RURAL HOSPITALS, HAVING COMPARATIVELY FEWER OUTLIERS, CONTRIBUTE LESS. THE OBRA 86 CHANGES REDUCED THE DIFFERENCE BETWEEN THE URBAN AND RURAL PAYMENT RATES BY ONE-THIRD.
- O OBRA 87 GAVE RURAL HOSPITALS HIGHER PPS UPDATES FOR BOTH FY 88 AND FY 89. ALSO, RURAL HOSPITALS IN FOUR REGIONS - NEW ENGLAND, EAST NORTH CENTRAL, MID-ATLANTIC, AND SOUTH ATLANTIC - WILL BE PROTECTED BY THE "REGIONAL" FLOOR FROM PAYMENT REDUCTIONS DUE TO THE COMPLETION OF TRANSITION. RURAL HOSPITALS IN THE REMAINING REGIONS WILL BENEFIT AS THEY COMPLETE THE TRANSITION THIS YEAR FROM LOWER HOSPITAL-SPECIFIC PAYMENT RATES TO HIGHER NATIONAL PAYMENT RATES.

THE PPS CHANGES IN OBRA 86 AND OBRA 87 HAVE SIGNIFICANTLY "LEVELED THE PLAYING FIELD" FOR RURAL HOSPITALS RELATIVE TO URBAN HOSPITALS. WE BELIEVE THE PAYMENT DIFFERENTIALS THAT REMAIN ARE LARGELY REFLECTIVE OF DIFFERENCES IN COSTS OF CARE BETWEEN URBAN AND RURAL HOSPITALS.

PPS NEEDS TO BE RESPONSIVE TO CLEARLY DEFINED PAYMENT PROBLEMS WHERE THE CAUSE CAN BE PINPOINTED. THEREFORE, WE ARE CONTINUALLY EXAMINING ASPECTS OF THE HOSPITAL PAYMENT SYSTEM WHERE IMPROVEMENTS MIGHT BE MADE. FOR EXAMPLE, AFTER CONSIDERABLE RESEARCH ON THE ISSUE, OUR NOTICE OF THE PROPOSED FY 89 PPS RATES INCLUDES A PROPOSAL TO REFINE OUR OUTLIER PAYMENT POLICY TO PROVIDE BETTER PROTECTION FOR THE MOST EXPENSIVE OUTLIER CASES. WITH RESPECT TO RURAL HOSPITALS, WE NOTED THAT THEY TEND TO HAVE LESS INSURANCE PROTECTION FOR OUTLIER CASES THAN URBAN HOSPITALS, EVEN THOUGH THEY TEND TO BE SMALLER AND MORE VULNERABLE. ALTHOUGH WE ARE NOT PROPOSING A CHANGE AT THIS TIME, WE HAVE REQUESTED COMMENTS ON WHETHER WE SHOULD INCREASE THE AMOUNT OF OUTLIER PROTECTION FOR RURAL HOSPITALS BY REDUCING THE THRESHOLDS FOR IDENTIFYING RURAL OUTLIER CASES. THIS WOULD REQUIRE INCREASING THE SIZE OF THE RURAL OUTLIER POOL BY MAKING A CORRESPONDING REDUCTION IN THE BASIC RURAL PAYMENT AMOUNT. THE COMMENT PERIOD ON THE PROPOSED NOTICE WILL CLOSE JULY 26.

WE BELIEVE THAT THE CURRENT PPS RATES, AS WELL AS THE FY 89 UPDATES ESTABLISHED IN OBRA 87, ARE ADEQUATE TO MEET THE COSTS OF EFFICIENT HOSPITALS, HOWEVER, IT IS ALSO IMPORTANT TO REALIZE THAT THE OVERALL AVERAGE MEDICARE PROFIT MARGINS FOR ALL HOSPITALS HAVE FALLEN FROM THE HIGH LEVELS IN THE FIRST FEW YEARS OF PPS. WE IN THE ADMINISTRATION AND YOU IN CONGRESS MUST BE VIGILANT TO CONTINUE TO ESTABLISH PAYMENT RATES THAT ASSURE ACCESS TO HIGH QUALITY CARE BUT ALSO PROVIDE INCENTIVES FOR EFFICIENT OPERATION. I WOULD ONLY POINT OUT THAT THIS CONCERN IS AN ISSUE OF IMPORTANCE FOR ALL HOSPITALS.

ACCESS TO CARE

IT IS IMPORTANT TO KEEP IN MIND THAT THE FINANCIAL PRESSURES EXPERIENCED BY RURAL HOSPITALS CANNOT AND SHOULD NOT BE SEEN AS AN EXCLUSIVELY OR EVEN PRIMARILY MEDICARE PROBLEM. MANY FACTORS HAVE CONTRIBUTED TO THE PLIGHT OF RURAL HOSPITALS INCLUDING AT LEAST:

- RECESSION IN THE AGRICULTURAL SECTOR
- DECLINING POPULATIONS IN RURAL AREAS
- INDIVIDUALS SEEKING CARE AT URBAN HOSPITALS

WE BELIEVE THAT OUR PAYMENT RATES SHOULD BE EQUITABLE BUT THAT MEDICARE SHOULD NOT BE USED AS A SUBSIDY TO INSURE THE SOLVENCY OF ALL RURAL HOSPITALS. FRANKLY, THERE ARE RURAL HOSPITALS WITH OCCUPANCY RATES OF 10 - 20 PERCENT THAT HAVE NOT MET THE MARKET TEST BECAUSE PEOPLE HAVE DECIDED TO USE OTHER MODES OF CARE.

DECLINING OCCUPANCY IN MANY RURAL HOSPITALS HAS MADE IT DIFFICULT, IF NOT IMPOSSIBLE IN SOME INSTANCES, TO PROVIDE SUFFICIENT COMMUNITY SUPPORT TO MAINTAIN A FULL SERVICE, HIGH QUALITY HOSPITAL. WE NEED TO CONSIDER ALTERNATIVE HEALTH CARE DELIVERY SYSTEMS TO MAINTAIN ADEQUATE ACCESS TO NECESSARY CARE

FOR MEDICARE BENEFICIARIES IN RURAL AREAS. THIS MAY INVOLVE REGIONAL SOLUTIONS SUCH AS ESTABLISHING INNOVATIVE PRIMARY AND EMERGENCY CARE SYSTEMS IN CERTAIN RURAL AREAS WITH ARRANGEMENTS TO PROVIDE SECONDARY AND TERTIARY CARE WHEN THE NEED ARISES. IT CERTAINLY WILL INVOLVE WORKING IN CONCERT WITH STATE AND LOCAL GOVERNMENTS SINCE THEY UNDERSTAND THE UNIQUE NEEDS OF THEIR CITIZENS.

HCFA ANNOUNCED FUNDING LAST WEEK OF ONE PROMISING ALTERNATIVE, A FOUR-YEAR DEMONSTRATION AT 5 RURAL HOSPITALS IN MONTANA. DUBBED THE "MONTANA MEDICAL ASSISTANCE FACILITY", THIS NEW KIND OF HEALTH CARE FACILITY WILL PROVIDE CARE AT A LEVEL MIDWAY BETWEEN A RURAL HEALTH CLINIC AND A RURAL HOSPITAL. INPATIENT CARE WILL BE LIMITED TO FOUR DAYS OR THE CARE THAT IS NEEDED BEFORE A PATIENT CAN BE TRANSFERRED TO A HOSPITAL.

PPS CONTAINS SPECIFIC PROVISIONS DESIGNED TO ASSURE MEDICARE BENEFICIARIES HAVE ADEQUATE ACCESS TO CARE IN RURAL AREAS. SPECIAL PROTECTIONS ARE AFFORDED TO SOLE COMMUNITY HOSPITALS - HOSPITALS THAT ARE ISOLATED FROM OTHER HOSPITALS BY DISTANCE, GEOGRAPHY, OR WEATHER AND REPRESENT THE SOLE SOURCE OF CARE REASONABLY AVAILABLE IN A GEOGRAPHIC AREA. DESPITE THESE PROTECTIONS, OUR ANALYSIS INDICATES THAT SOLE COMMUNITY HOSPITALS HAVE SUBSTANTIALLY LOWER MEDICARE PROFIT MARGINS THAN ALMOST ALL OTHER CLASSES OF HOSPITALS. IN 1986, THE PROFIT MARGIN FOR SOLE COMMUNITY HOSPITALS WAS 1.57 PERCENT COMPARED TO THE NATIONAL AVERAGE OF 8.93 PERCENT. IF CURRENT PAYMENT RULES HAD APPLIED, PROFIT MARGINS WOULD STILL HAVE BEEN ABOUT HALF THE NATIONAL AVERAGE. WE ARE ASSESSING WHETHER MODIFICATIONS ARE NEEDED TO IMPROVE THE FINANCIAL VIABILITY OF SOLE COMMUNITY HOSPITALS.

SPECIAL PAYMENT CONSIDERATIONS ARE ALSO AFFORDED RURAL REFERRAL CENTERS. IN GENERAL, RURAL REFERRAL CENTERS ARE LARGE RURAL HOSPITALS THAT SERVE AS TERTIARY CARE CENTERS AND ARE PAID AT THE URBAN RATE. OUR DATA SHOW THAT RURAL REFERRAL CENTERS, WHOSE COSTS ARE HIGHER THAN OTHER RURAL HOSPITALS BUT LOWER THAN URBAN HOSPITALS, HAD A MEDICARE PROFIT MARGIN OF 7.8 PERCENT IN 1986. IF CURRENT PAYMENT RULES HAD APPLIED, THE MEDICARE PROFIT MARGIN WOULD HAVE BEEN AMONG THE HIGHEST OF ANY CLASS OF HOSPITALS. WE ARE EVALUATING WHETHER, IN VIEW OF THE OBRA CHANGES, MODIFICATION IN THE RURAL REFERRAL CENTER POLICY WOULD BE APPROPRIATE.

RESEARCH ACTIVITIES

SINCE THE INCEPTION OF THE PPS, A SIGNIFICANT PORTION OF HCFA'S RESEARCH EFFORT HAS BEEN DEVOTED TO AN ANALYSIS OF THE EFFECT OF PPS ON RURAL HOSPITALS. MUCH OF THIS INFORMATION HAS PROVIDED THE BASIS FOR LEGISLATIVE CHANGES IN PPS PAYMENT POLICIES. REPORTS TO THE CONGRESS THAT HAVE BEEN RELEASED IN THE PAST SIX MONTHS INCLUDE SPECIAL STUDIES DEALING WITH URBAN-RURAL PAYMENT ISSUES, SOLE COMMUNITY HOSPITALS, RURAL REFERRAL CENTERS, THE RURAL HOSPITAL SWING-BED PROGRAM, AND THE IMPACT OF OUTLIER AND TRANSFER POLICIES ON RURAL HOSPITALS.

WE HAVE ALSO UNDERTAKEN CHANGES IN DEVELOPING OUR RESEARCH AGENDA AND SOLICITING PROPOSALS THAT ARE EXPECTED TO INCREASE THE NUMBER OF HIGH-QUALITY RESEARCH AND DEMONSTRATION PROPOSALS THAT FOCUS ON RURAL HEALTH CARE ISSUES.

- WE PLAN TO HIGHLIGHT OUR INTEREST IN RURAL HEALTH CARE INITIATIVES IN OUR FY 89 GRANTS SOLICITATION FOR NEW PROJECTS. WE WILL CONTINUE TO PROVIDE TECHNICAL ASSISTANCE AND REGIONAL MEETINGS TO EXPLAIN THE RESEARCH AND DEMONSTRATION APPLICATION PROCESS TO POTENTIAL CONTRIBUTORS WITH RURAL PERSPECTIVES, SUCH AS WE DID LAST YEAR IN KANSAS CITY.
- WE WILL CONVENE A PANEL OF EXPERTS IN THE FIELD OF RURAL HEALTH CARE EARLY THIS FALL WITH THE GOAL OF ESTABLISHING A COORDINATED AGENDA OF RESEARCH AND DEMONSTRATION INITIATIVES TARGETING AREAS IN NEED OF STUDY.

IN ACCORDANCE WITH OBRA 87, WE WILL SET ASIDE 10 PERCENT OF OUR RESEARCH BUDGET FOR PROJECTS DEALING EXCLUSIVELY OR SUBSTANTIALLY WITH RURAL HEALTH CARE ISSUES.

OFFICE OF RURAL HEALTH

RECOGNIZING THAT CHANGING DEMOGRAPHICS, ECONOMICS AND OTHER FORCES AFFECT THE DELIVERY OF RURAL HEALTH CARE, THE SECRETARY ESTABLISHED THE OFFICE OF RURAL HEALTH LAST SUMMER. CONGRESS, IN OBRA 87, FORMALIZED THE EXISTENCE OF THE OFFICE AND MANDATED SUCH SPECIFIC RESPONSIBILITIES AS ADVISING THE SECRETARY ON:

- THE EFFECT OF MEDICARE AND MEDICAID POLICIES ON THE FINANCIAL VIABILITY OF SMALL RURAL HOSPITALS;

- O THE ABILITY OF RURAL AREAS AND HOSPITALS TO ATTRACT AND RETAIN PHYSICIANS AND OTHER HEALTH PROFESSIONAL; AND
- O ACCESS TO AND QUALITY OF HEALTH CARE IN RURAL AREAS.

WITHIN THE DEPARTMENT, THE OFFICE ADDRESSES THE BROAD ISSUES AND PROBLEMS THAT RURAL PROVIDERS FACE, AND SERVES AS A FOCAL POINT TO COORDINATE NATIONWIDE EFFORTS TO IMPROVE THE DELIVERY OF HEALTH SERVICES IN RURAL AREAS. THE OFFICE WILL ALSO ADMINISTER A NATIONAL GRANT PROGRAM TO ESTABLISH BETWEEN THREE AND FIVE RURAL HEALTH RESEARCH CENTERS. OVER $1 MILLION IN GRANTS WILL BE AWARDED BY SEPTEMBER. THE OFFICE IS CURRENTLY NEGOTIATING A CONTRACT TO INITIATE A NATIONAL CLEARINGHOUSE FOR THE COLLECTION AND DISSEMINATION OF RURAL HEALTH INFORMATION. I AM PLEASED TO REPORT TO YOU THAT HCFA HAS DEVELOPED AN EXCELLENT COOPERATIVE RELATIONSHIP WITH THE OFFICE OF RURAL HEALTH AND THAT WE MEET TOGETHER REGULARLY.

THE SECRETARY HAS ALSO RECENTLY APPOINTED A SPECIAL COMMITTEE OF PRESTIGIOUS EXPERTS IN THE FIELD OF RURAL HEALTH CARE TO ADVISE HIM ON RURAL HEALTH ISSUES.

CONCLUSION

IN CONCLUSION, I WANT TO EMPHASIZE THAT THE MEDICARE PROGRAM IS COMMITTED TO MAKING FAIR PAYMENTS TO ALL HOSPITALS FOR CARE PROVIDED TO MEDICARE BENEFICIARIES, REGARDLESS OF THEIR LOCATION. HOWEVER, IT IS NOT EQUITABLE OR EFFICIENT THAT MEDICARE SHOULD BE THE EXCLUSIVE SOURCE OF INCREASED FUNDING FOR RURAL HOSPITAL ACCESS. IMPLEMENTATION OF RECENT STATUTORY CHANGES WILL PROVIDE A BETTER BALANCE IN PAYMENTS TO URBAN AND RURAL HOSPITALS, BUT WILL NOT ELIMINATE EITHER ECONOMIC OR NONMEDICARE-RELATED PROBLEMS EXPERIENCED BY RURAL HOSPITALS. FURTHERMORE, WE AND CONGRESS MUST MAINTAIN OUR VIGILANCE TO BE CERTAIN OVERALL PAYMENT RATES FOR ALL HOSPITALS ARE ADEQUATE AND ARE ESTABLISHED IN A MANNER THAT CONTAINS INCENTIVES FOR IMPROVED EFFICIENCY. FINALLY, LET ME ASSURE YOU THAT WE WILL CONTINUE OUR EFFORTS TO BETTER UNDERSTAND RURAL PROBLEMS AND NEEDS AND TO FIND BETTER WAYS TO MAKE EQUITABLE AND APPROPRIATE MEDICARE PAYMENT TO ALL HOSPITALS.

The CHAIRMAN. Mr. Anthony, subsidy has been mentioned several times by witnesses, and you have mentioned it again. Medicare should not—I am quoting you out of context—but rural hospitals shouldn't be dependent upon Medicare subsidization. That is a fair assessment of your statement, is it not?

Mr. ANTHONY. I think I put it a little differently, and that is I think——

The CHAIRMAN. Let's have you put it the way you put it then.

Mr. ANTHONY. What is important, I think, is for Medicare to pay fairly for the services offered to Medicare beneficiaries. The reason we use profit margins is to look at the payment equity of differentials between urban and rural settings. It is certainly true in the first few years of PPS that profit margins in urban hospitals are much higher than for rural hospitals, leading one to say that the system that we created wasn't equitable because we weren't paying fairly.

But let's say that we use the PPS system. Although frankly, it is not an instrument as precise as we might hope, but we are able to pay for the costs, at least cover the costs, and pay while having incentives for efficiency within the system to rural and urban hospitals.

The next question is the issue of subsidy. Do we wish to use this instrument as a way to maintain the solvency of rural hospitals who might have problems that go beyond, say, the Medicare program. One major problem is just lack of occupancy.

We don't believe that Medicare should be used as an instrument for that type of policy. If Congress were to decide that they did wish to maintain the solvency of all hospitals, and that certainly is something that is a policy you ought to address, we would feel that you ought to do that in a different program and not change a program that is designed primarily to pay equitably but to promote efficiency also within all hospital systems.

The CHAIRMAN. Well, you have used the term, however you want to couch it, as what is quite often generally accepted by the public, that payment that comes out of Federal money is a subsidy. Now, most of us on this committee are very familiar with subsidies. We deal with them all the time, and, by and large, a subsidy is provided federally at a uniform price.

I believe the differential cannot be explained away by saying well, there is different inputs, because we don't see different inputs.

Mr. ANTHONY. May I answer the question? The answer is yes, there is a different payment. The standardized amounts in the recently published Register show this. I will give them to you. The rural rate, on average, is $2,812; the urban rate is $3,165. That is as $359 differential.

That differential is there because of the law. As a matter of fact, when the PPS system was first proposed to Congress, it did not contain an urban-rural differential, and Congress added that differential in its deliberations.

The differential is there to reflect what is thought to be differences in costs and differences in case mix. Unfortunately, as you have heard earlier, when you draw lines like you draw them around cities, there are people that are on the borders who are subject to the same input costs as the people in the cities, but they happen to fall just on the other side of the line. There are people who are way, way beyond who may in fact have much lower than the average input cost, and when you average it out together, you end up creating a rate.

There are situations, certainly, that end up with problems because of the fact that you are arbitrarily drawing a line around cities. I would be the first to agree with your statement that there is a difference, and I think the real issue for us is whether or not that is a difference that is appropriate and that you wish to maintain.

Admitting that the Prospective Payment System is not a very detailed surgical instrument—it is a blunt instrument at best—do you wish to maintain a differential on average because of lower on average costs and lower on average case mix that will have problems in specific circumstances or not?

The CHAIRMAN. No, we do not, but we find it rather difficult dealing with what we have had coming out of your office and out of HCFA in general of why not correct this. We seem to get rather fuzzy answers.

I think perhaps you have given us the straightest answer we have received, because you have said, well, there is a difference. You say it is $400. Mr. Size says it is somewhere between $700 and $900. Why do you get a difference with what he has?

Mr. ANTHONY. Well, I think I can explain that. I am just guessing, but there are probably two reasons. One is my figures are more up to date and therefore reflect some of the differences in the update factors that were passed into law recently.

But when you look at these—and I used standardized amounts—there are other payments to Medicare hospitals that go beyond the standardized amounts, such as payments for medical education and, payments for disproportionate share. More teaching hospitals in fact are in urban areas and disproportionate share tends to go more to urban areas. Therefore, you will find that the total amount of dollars flowing tend to be accentuated further than those numbers I gave you when you start adding in these different payments that were designed by Congress to pay for other circumstances.

My guess would be that this is probably influencing these numbers, but I don't know for certain.

The CHAIRMAN. Do you think HCFA is going to give us a rather positive recommendation, or do you think we are going to have to ferret it out with holding these hearings? You are not really making the recommendation, Dr. Anthony, that we take care of this disparity?

Mr. ANTHONY. Let me tell you what I hope HCFA does, and I think we are today doing it. I can't speak for some periods before I was at HCFA which has been two years.

We have tried to aggressively go forward on an agenda to gather data and information so that the extent of the problem and the reasons for its existence become clear both to you and the Administration so that in fact we can make good policy judgments. I hope that you feel that I am being very honest and straightforward with you with the data and information that I have, because I am.

I think we need to continue to analyze the problem. I am not in a position today as an Administration official to say that we will recommend that we do away with the differential, but I think we should look at it and look closely at it.

There are other ways to differentiate between hospitals that have been proposed, but I do hope that we provide you with information and data and are as responsive to you as we possibly can be so that we all can look at this question and try to find the best answer for it.

The CHAIRMAN. Thank you, Mr. Anthony.

Senator Burdick.

Senator BURDICK. Thank you, Mr. Chairman.

Dr. Anthony, as you know, Congress is interested in the development of a sound working relationship between the Office of Rural Health Policy and HCFA. Tell me how it is going.

Mr. ANTHONY. I think it is going very, very well. We have had numerous meetings. I coordinate the activity for HCFA, and I have talked and met periodically with Jeff Human who is the Director of the Office of Rural Health Policy.

We have coordinated and talked about activities. We are developing a memorandum of understanding presently to lay out that relationship more clearly. They comment on all of our regulations, and I personally am very pleased with the way in which the relationship so far has developed.

Senator BURDICK. Some of us who have been active on behalf of rural hospitals remember that when PPS began, the Department was required to write a report on the effects of the urban-rural differential on rural hospitals and discuss the feasibility of eliminating the differential. That report was due to Congress in 1985. I remember hearing Bill Roper promise in a hearing in 1986 that the report would be finished that year.

Mr. Anthony, as you know, this is 1988. Where is that report and when can we expect it?

Mr. ANTHONY. Bill Roper put a bug under all of our britches and said you guys get those reports out as quickly as you can. They were, as you know, late when he arrived.

That report was delivered to Congress on December 24, 1987. It wasn't exactly on time, but I will say that our record of delivering on reports on schedule has greatly improved. Whereas we still have a ways to go, I think you will find that our timeliness and responsiveness in the recent year has been greatly improved.

I would be glad to send you another copy for your personal use if you would like me to.

Senator BURDICK. That is exactly what I would like.

Mr. ANTHONY. Okay.

Senator BURDICK. It has been three years. I don't have a copy.

[Subsequent to the hearing, the following information was received for the record:]

STUDIES OF URBAN-RURAL AND RELATED GEOGRAPHICAL ADJUSTMENTS IN THE MEDICARE PROSPECTIVE PAYMENT SYSTEM

EXECUTIVE SUMMARY

The Social Security Amendments of 1983, the Deficit Reduction Act of 1984, and the Consolidated Omnibus Budget Reconciliation Act of 1985 mandate a series of studies of the geographical aspects of the PPS payment formula. Three of the studies deal with the use of standardized payment amounts (payment rates) computed on an urban-rural, regional, or hospital-specific basis. Two other studies concern the adjustment of the payment rates for differences in labor-related costs. The specific mandates addressed in this report are:

- Separate urban and rural payment rates — Section 603(a)(2)(C)(i) of the Social Security Amendments of 1983 mandated studies of "the feasibility and impact of eliminating or phasing out separate urban and rural DRG prospective payment rates."
- Regional payment rates — Section 603(a)(2)(A) of the same Act mandated a study of "the impact of computing DRG prospective payment rates by census division, rather than exclusively on a national basis." Section 2311(f) of the Deficit Reduction Act of 1984 also calls for "a discussion of the relative merits of a method of payment under which a percentage of the payment amount (for discharges classified within a diagnosis-related group) could be determined on a regional basis."
- Hospital-specific payment rates — Section 2311(f) of the Deficit Reduction Act of 1984 mandated "a study of further refinements which may be appropriate in the inpatient hospital prospective payment provisions of Title XVIII of the Social Security Act, in order to address the problems of differences in payment amounts to specific hospitals."
- Urban wage index — Section 9103 of the Consolidated Omnibus Budget Reconciliation Act of 1985 mandates a study of refinements in the urban wage index, specifically consideration of distinguishing between the central city core and the suburban ring of metropolitan areas.
- Varying proportions of labor and non-labor components among DRG's — Section 2311(e) of the Deficit Reduction Act of 1984 also mandates "a study of the distinction between urban and rural hospitals for purposes of the DRG payment provisions under section 1886(d) of the Social Security Act, and the effect which such distinction may have on rural hospitals in the case of those DRG's which do not vary significantly between urban and rural areas (such as those DRG's which involve expensive medical devices.)" This section also requires investigation of the advisability and feasibility of varying by DRG the proportions of the labor and nonlabor components of the Federal payment amount instead of applying the average proportion of those components to all DRG's.

The mandated studies reflect concerns that PPS avoid or minimize unintended adverse consequences and ensure that outcomes in general are reasonable and equitable. This report addresses these concerns by examining the following questions:

- Are refinements needed to assure that hospitals are not systematically advantaged or disadvantaged under PPS by virtue of their geographical location?
- What types of refinements would be desirable? Three broad types of modifications were considered:
    - Refined adjustments for differences in the "output" of hospitals, as measured by case mix or possibly by the scale and scope of services

- Refined input price adjustments, such as alternative ways of defining urban and rural labor market areas and varying the labor-nonlabor proportions by DRG
- Other geographical adjustments, such as retaining regional and hospital-specific rates

Extensive computer analyses of Medicare and American Hospital Association data were conducted for this report. A micro-simulation model was used to examine the relationship between hospitals' PPS operating payments and their operating costs (the Medicare "operating margin"). These analyses and the conclusions drawn from them are based on the assumption that a "fair" system yields similar operating margins for different types of hospitals. This assumption, while debatable, is a reasonable guideline if it is not too rigidly applied. Rigidly applied, it leads back to cost reimbursement. The assumption is reasonable because after hospitals are grouped by characteristics such as size and location, it seems unlikely that differences in costs among hospital groups are primarily attributable to differences in hospital efficiency. Consequently, comparisons of group operating margins are used in the report as the best available indicator of payment equity. These simulations assume that hospitals have the same cost experience regardless of payments. Recent studies have shown that hospitals' cost experience varies depending on payments received, which would alter the findings of this study. The data analyses yielded the following major findings:

1. Simulated Medicare operating margins imply that the technical changes in the method of computing the payment rates, enacted in OBRA 1986, will correct a systematic payment bias that has favored urban hospitals at the expense of rural hospitals. OBRA 1986 replaces a uniform 5 percent rate adjustment for outlier payments with separate urban and rural adjustments and replaces hospital-weighting with case-weighting in the computation of the rates.

2. Under current law, several groups of hospitals that receive special treatment under PPS are expected to be unfairly advantaged:

   - Disproportionate share hospitals (DSH). Particularly advantaged are rural and small urban DSH hospitals. The simulated operating margin for all rural DSH hospitals is 100 percent greater than the margin for all rural hospitals. The operating margin for urban DSH hospitals of less than 100 beds is expected to be almost as high as that for rural DSH hospitals. Less advantaged are the large urban DSH hospitals whose margin is expected to be slightly greater than the margin for all urban hospitals.

   - Rural Referral Centers (RRCs). RRCs are expected to have an operating margin that is two-thirds greater than the margin for all rural hospitals. More detailed analyses and recommendations for RRCs are presented in a separate report.

   - Teaching hospitals. Hospitals with large teaching programs (a resident-to-bed ratio greater than .25) are expected to have an operating margin about 20 percent higher than the margin for all urban hospitals.

3. Simulated margins imply that, as a group, small hospitals (those with fewer than 100 beds) will be systematically advantaged. The result is especially striking for rural hospitals with fewer than 50 beds, whose simulated margin is 50 percent higher than that of all rural hospitals. In contrast, the operating margin of sole community hospitals is only one-half that of all rural hospitals. The special situation of sole community hospitals is addressed in a separate report.

4. Overall, hospitals in the central city core of metropolitan areas do not appear to be disadvantaged relative to suburban ring hospitals. This result most likely can be attributed to the fact that many core hospitals qualify for indirect medical education and/or disproportionate share payments. The main effect of a core-ring wage index would be to eliminate above average margins for a subset of suburban ring hospitals.

5. Fully national rates in FY 1988 are expected to result in significant variation in Medicare operating margins among regions:

   - Simulated margins for urban hospitals in New England and the East North Central regions are only one-third and two-thirds as large as the margin for all urban hospitals. However, the result for New England is due to the inclusion of Massachusetts hospitals, which were not covered by PPS in the year of the PPS-1 cost report. When Massachusetts hospitals are excluded, the New England region is near the national average.

   - Urban hospitals in three regions have simulated margins that are 20-30 percent higher than the margin for all urban hospitals. These regions are Middle Atlantic, West North Central, and West South Central. However, if New York hospitals are excluded (their data are pre-PPS), the Middle Atlantic region is closer to the national average.

   - Rural hospitals in three regions have simulated margins substantially lower than the margin for all rural hospitals. The Middle Atlantic, New England, and East North Central margins are approximately one-fourth, one-half, and two-thirds of the overall rural margin. However, if New York hospitals are exluded, the Middle Atlantic region's margin is slightly above the national average.

   - Among rural hospitals, only one region stands out with a simulated margin substantially greater than the overall rural margin. The West South Central margin is 30 percent higher than the rural average.

Refined hospital "output" measures

Separate urban and rural payment rates are a means of accommodating the fact that, on average, urban hospitals have higher operating costs per case than do rural hospitals, after controlling for differences in DRG case mix and the wage index. The PPS adjustments for teaching, disproportionate share, and rural referral center hospitals are further accommodations to the fact that separate urban and rural rates do not account for high cost hospitals within the urban and rural groups. Findings #2 and #3 above indicate the problems with this approach. First, relatively high cost hospitals identified for special treatment tend to be overcompensated. Second, within the urban and rural groups, relatively low cost hospitals tend to reap windfalls.

Research suggests that these problems could be mitigated by incorporating into PPS refined measures of hospital "output." Research on these refinements should focus on urban-rural differences in the style of practice. Physicians in urban hospitals practice a more technology-intensive style of medicine that is not reflected in measures of DRG case mix or severity of illness. There is a strong correlation between procedure intensity, hospital size, and teaching activity. Research suggests that the extent to which a hospital receives patients on referral could be used to capture these differences in place of, or in addition to, some combination of the urban-rural and teaching measures. In time, it might be possible to develop a PPS with one or more continuous payment variables (such as a referral index) that is used to adjust a single national payment rate. Such an adjustor could account for observed urban-rural and bedsize cost differences in a more graduated fashion that is more closely related to the underlying sources of cost variation. Teaching, disproportionate share, and rural referral center adjustments would all be reevaluated in a single rate system of this type.

Refined input price measures

Detailed analyses were conducted of wage differences among urban and rural hospitals. These analyses supported the hypotheses that urban core hospitals usually pay higher wages than suburban ring hospitals; and rural hospitals closer to urban areas usually pay higher wages than rural hospitals in more outlying areas. These findings suggest the desirability of further refinement of the PPS wage adjustment, but do not yield easy methods of doing so. Additional findings to be noted in considering wage index refinements include the following:

- The current wage index is not a source of major payment inequities. Only 17 percent of urban hospitals and 20 percent of rural hospitals have wage indexes that are less than 95 percent of their own wages.
- As noted earlier, simulated operating margins do not reveal a disparity between the group margins of urban core and suburban ring hospitals.
- An alternative wage index, based on a core-ring distinction for all urban areas and BEA-based rural wage areas, produced a small reduction in the variation of simulated operating margins among selected categories of hospitals.
- Most of the impact occurred within urban areas. Suburban ring hospitals would experience a noticeable decline in operating margins. The proportion of core and ring hospitals with operating margins in excess of 20 percent would be more equal. However, core hospitals as a group are overcompensated relative to ring hospitals.
- Several issues need to be resolved to demonstrate that a core-ring wage index would improve PPS payment equity. Chief among them is the interaction of core-ring location with teaching and disproportionate share status.
- Although research will continue on further refinements of the wage index for rural areas, no clear improvement over the current index is available at this time.

Differences in the prices of hospital inputs other than labor were also investigated for this report. The main conclusion of this effort was that there are currently no data available that would either permit adequate testing of hypotheses about variation in nonlabor prices, or form the basis for an index that could be used in PPS.

Finally, variation in the proportion of labor-nonlabor costs among DRGs was examined. Concern was expressed that hospitals in low-wage areas would be disadvantaged in treating DRGs with high proportions of nonlabor costs. Inassuming a constant labor share for all DRGs, PPS would underpay these hospitals for DRGs with relatively low labor cost shares by adjusting too much of their payment by the low wage index. The same logic implies that underpayment may also occur for labor intensive DRGs in high-wage areas. In addition, overpayment may occur for nonlabor intensive DRGs in high-wage areas and for labor intensive DRGs in low-wage areas. Depending on the extent of variation in labor shares across DRGs and the possibilities for over and under payment to occur within the same hospital, these biases might not have an appreciable impact at the hospital level. The analysis found that variation in labor shares across DRGs is small and is further reduced when hospitals' entire case mix is taken into account. These offsetting factors minimize any systematic bias from the use of a constant labor share.

Other geographical refinements

Differences in 4 PPS variables (DRG case mix, wages, teaching activity, and urban-rural location) explain about three-fourths of regional differences in operating costs per discharge. However, the remaining variation, whose effects are reflected in the regional variation in operating margins presented earlier, cannot be explained by existing PPS adjustments or any of the refined measures of hospital output or input price differences studied for this report.

A number of county economic and demographic conditions were examined and were found to account for about two-fifths of the regional cost variation not explained by the 4 PPS variables. County population density, rental housing costs, and per capita income were the most important variables. The impact of these variables on hospital costs is indirect, and may be due either to regional variations in hospital outputs or input prices not captured by PPS, or to regional variations in efficiency.

Continuation of the regional and hospital specific rates are ways of correcting for these potential biases. Regional rates would shelter certain geographically concentrated groups of hospitals and reduce potential windfalls to others. However, as hospitals respond to PPS incentives, and as additional refinements are incorporated, the need for regional rates may be eliminated.

It might appear that retaining hospital specific rates would automatically adjust for imperfections in the payment formula, and to a certain extent it would. However, the simulation analysis produced an interesting result. The main impact of retaining hospital specific rates would be to reduce the number of hospitals with large positive operating margins. The number of hospitals with large negative operating margins would not be reduced. This result highlights the fact that costs have changed significantly for some hospitals since the 1982 hospital specific base year. The longer the original hospital specific rates are used, the more important becomes the issue of updating them. All things considered, the principal argument against retaining hospital specific rates is that varying payment rates among hospitals in a single locality would be perpetuated, thereby providing a competitive advantage to hospitals with higher historical costs, regardless of the reason for the higher costs.

Finally, even if regional and hospital specific rates were retained, it is not clear what weight should be given each component. The simulations conducted for this report do not offer clear cut guidelines on this issue. It is only possible to identify potential winners and losers under alternative circumstances. It is not possible to assess whether one set of winners and losers is more appropriate than another.

Mr. ANTHONY. I don't know what distribution system you use up here, but the report was delivered to Congress.

Senator BURDICK. In the fall of 1987?

Mr. ANTHONY. My records here indicate it was delivered on December 24, 1987.

Senator BURDICK. December 24?

Mr. ANTHONY. Yes, sir.

The CHAIRMAN. Merry Christmas.

Senator BURDICK. Happy New Year.

Mr. ANTHONY. Like I said, we were working late.

Senator BURDICK. That is about 3 years late. How do we get a copy?

Mr. ANTHONY. I will be glad to be sure you get one.

Senator BURDICK. All right. We accomplished something this morning then.

That is all. Thank you.

The CHAIRMAN. All right, thank you very much, Mr. Anthony.

The hearing record will remain open for 2 weeks. We will submit written questions to the Administration, to HCFA specifically, and any member of the committee may contribute their own questions, and we will submit them as a group or individually, however the committee members choose.

I believe that takes care of it all for this morning. The committee stands adjourned.

[Whereupon, at 12:17 p.m., the committee adjourned, to reconvene subject to the call of the Chair.]

THE RURAL HEALTH CARE CHALLENGE
PART 2: RURAL HEALTH CARE PERSONNEL

MONDAY, JULY 11, 1988

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 9:35 a.m., in room 628, Dirksen Senate Office Building, Hon. John Melcher (chairman of the committee) presiding.

Present: Senators Melcher, Burdick, Shelby, Heinz, Pressler, Grassley, Wilson, Chafee, Durenberger, and Simpson.

Staff present: Max Richtman, staff director; Chris Jennings, professional staff member; Jenny McCarthy, professional staff member; Annabelle Richards, professional staff member; Larry Atkins, minority staff director; Kelli Pronovost, hearing clerk; and Kimberly Kasberg, research associate.

OPENING STATEMENT BY SENATOR JOHN MELCHER, CHAIRMAN

The CHAIRMAN. The committee will come to order.

This morning, we are holding our second hearing on assuring access to health care in rural areas. The first hearing a few weeks ago centered on hospitals in rural areas.

During that hearing, we highlighted, among other things, Medicare's inequitable payment practices which reimburse hospitals in rural communities at lower levels than those that happen to be located in metropolitan areas. In other words, reimbursement for the exact same medical procedure is lower for rural hospitals for no other reason than the fact that the service was provided in a rural community, and that is perhaps the most important reason we are losing so many rural hospitals. It isn't the single reason for the loss of rural hospitals, but perhaps it is one of the major ones.

Another problem in rural areas connected with maintaining the viability of rural hospitals and other medical facilities is the availability of physicians, nurses and other affected health professionals. We can have all the facilities we want, but without these health professionals, we won't have access to needed medical care.

So, we will focus today on just what the situation is among health professionals in rural areas. A few years ago, we thought we had a physician shortage. Now, we are told we don't have a physician shortage. Yet, we find that the number of physicians in many rural areas is still inadequate or nonexistent.

What are we going to do about it? Well, we hope to shed some light on the problem through testimony we receive from witnesses who are from rural areas, who are in the health care profession, and who may have recommendations.

[The prepared statements of Senator Melcher, Senator Breaux, and Senator Reid follow:]

JOHN MELCHER, MONTANA, CHAIRMAN

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

OPENING STATEMENT

SENATOR JOHN MELCHER
Chairman, Senate Special Committee on Aging

July 11, 1988

THE RURAL HEALTH CARE CHALLENGE: PART 2: RURAL HEALTH CARE PERSONNEL

Good morning. On behalf of myself and the other members of the Special Committee on Aging, I would like welcome everyone to today's hearing on rural health care personnel issues. This morning we will be looking at the challenges rural America faces in attracting and retaining physicians, nurses, and other health care professionals. We also will hear about some of the innovative approaches that have been developed in an effort to effectively meet these challenges.

This is the second of two hearings the Committee will hold this summer on the rural health care system. Last month, at the first hearing in this series, we focused on rural hospital issues. Today's hearing on health care manpower shortages examines a problem that extends to and endangers every aspect -- including, hospitals, health clinics, community health centers, and practitioners -- of the rural health care system.

While it is true that the rise in the number of physicians in recent years has translated into significant increases in the number of rural practitioners, smaller rural communities, particularly those under 10,000, continue to experience serious physician shortages. In fact, the evidence shows that the smaller the community, the more severe the shortage.

The type of physician of greatest importance to a rural area is a primary care physician. Yet, the most recent data available tells us that 73 percent of the 1,292 areas designated by the Department of Health and Human Services as health care manpower shortage areas -- those areas where the ratio of residents to primary care physicians exceeds 3000 to 1 -- are found in rural America. Despite the growth in physician supply over the years, the number of medically underserved areas has not changed. This can be partly attributed to the financial incentives from both the public and private sectors that entice medical students to specialize, rather than become primary care physicians. As a result, those primary care physicians who choose to practice in rural areas are frequently over-extended and too often cannot meet all of the health care needs in their area.

In areas with severe physician shortages, the need for nurse practitioners and physician assistants becomes all the more urgent. It is these professionals that can often make the difference in whether a patient's medical needs are tended to. Unfortunately, the lack of data specifying where shortages in these professions are most serious stands in the way of our effectively addressing this problem. Clearly, we need to have such information.

As in many urban areas, nurse shortages are posing very serious problems for hospitals, clinics, and health care centers in rural areas. In fact, information presented to the Nurse Shortage Commission concludes that the lack of nursing personnel has forced 9% of rural hospitals to close some beds. Compounding such problems are shortages that run the spectrum of all allied health personnel.

With regard to mental health services, the Committee has just received a preliminary report by the National Center for Social Policy and Practice that finds that a startling number of mostly rural counties in six states have no psychiatrists, psychologists, or social workers. For example, 40 percent of the counties in Texas, 30 percent in Oklahoma, and 16 percent in Florida are without any mental health providers. This report, commissioned by the National Association of Social Workers, illustrates that access to needed mental health services is severely limited or non-existent in many rural areas.

This morning, we will be hearing more about these problems from those who grapple daily with health care personnel shortages. It is my hope that this hearing will contribute towards our efforts to effectively resolve these issues.

Opening Statement of Senator John Breaux

John Breaux

Senate Special Committee on Aging
July 11, 1988

Rural Health Care Personnel

Mr. Chairman, I would like to take this opportunity to commend you for holding this two part series of hearings on the problems that are facing health care systems in rural areas. The June 13, 1988 hearing, which concentrated on the problems faced by rural hospitals, included a distinguished list of witnesses and painted a pretty thorough picture of the fiscal and logistical problems involved in providing rural health care in the 1980's. I look forward to an equally impressive list of witnesses today as we discuss the personnel problems that rural health care systems are facing.

We know that patients in rural areas are likely to be older. Because they are older, they are likely to require more expensive, more acute care. They are also more likely to be indigent and uninsured. The ability of rural health care systems to continue to operate on a sound financial basis is heavily dependent, as is any other industry, on the surrounding economic environment. The economic fallout of the drought that is having such a devastating effect on rural America will only serve to increase the number of indigent and uninsured persons in these areas and to make rural practice less attractive for physicians, nurses and related health care professionals.

The Medicare Prospective Payment System will continue to tighten up on reimbursements to health care providers and to reduce the number of hospital beds that are kept full. There is little doubt in my mind, and a number of studies bear me out on this, that we will continue to lose quite a few more small rural hospitals. According to the Louisiana Hospital Association, their industry is the third largest in the state. Louisiana is already reeling from some of the highest unemployment rates in the nation. Each closure not only potentially endangers access to acute care, but contributes to this problem.

Despite increasing numbers of medical school graduates, rural areas in Louisiana and across the United States are having a hard time attracting physicians. Over the last year, I have been contacted by too many desperate Parish hospital directors who were losing either their parish's sole physician or one of only two. All are located in poor rural areas and were seeking help from the National Public Health Service Corps. We need to strengthen federal involvement in programs like this one that will get physicians and other health care professionals to the areas that need them the most.

For numerous reasons, all well documented, it is extremely difficult to attract physicians into the countryside. A doctor would be much closer to the latest developments in technology and procedure were he working in a large urban hospital than if he were working out of the Parish hospital in Tensas Parish, Louisiana. Both doctors are providing invaluable services, but both are not compensated at the same level nor are both afforded the same opportunity to keep up with the latest developments in their chosen field of medicine.

As the economies of rural areas continue to decline, we are also finding that physicians are less and less willing to go rural out of a desire to provide a better quality of life for their families. We know that, as his or her career progresses, a physician is much more likely to move to a more heavily populated and urbanized area from a less populated area than the other way around.

A related trend can be seen in the continuing malpractice insurance crisis which is forcing many physicians to retire early or simply quit practicing certain kinds of medicine. The malpractice situation is begging for a comprehensive solution--doctors, lawyers and insurance companies are even beginning to agree on the need. One example of the consequences of this situation has been a huge increase in the number of obstetricians who will no longer deliver babies. The United States has one of the highest infant mortality rates among the industrialized nations--if anything, we need to attract people into this field. We cannot sit and watch them be chased out of it.

A continuing shortage of nursing personnel at all levels; Registered Nurses, Licensed Professional Nurses and Nurse Practitioners, continues to hamper the delivery of adequate and affordable care. Rural areas are having the worst time, because their nursing staffs are often lured away by urban hospitals with higher wages and better working conditions. We have seen a tremendous growth in the demand for nurses over the last fifteen years and more recently a drop in the number of nurses available to fill these positions. In 1972 the average nurse to patient ratio was fifty nurses to one hundred patients. In 1986 it was ninety-one to one hundred.

Unfortunately, though, as the demand for nurses grows, the supply has not kept up. In one year, from 1985 to 1986, the vacancy rate for hospital nursing personnel practically doubled. Projections for the next ten years show that the number of nursing school graduates will fall even more. The most obvious reasons for the unwillingness of men and women to pursue a nursing career are the low pay and demanding nature of the work that they can expect. Nursing has traditionally been a female dominated profession, but today women have more opportunities for a professional career than they have in the past. Why should a woman today, when she could just as easily become a doctor or lawyer or banker, choose a low paying nursing career which does not offer great opportunity for advancement? The answer to this question should lie primarily with the hospitals that employ nurses, but the federal government can help by continuing to assist individuals who choose to pursue a career in this field with access to a proper education.

In summary, we know what the problems are and why they exist. If we are to solve them and, in so doing, preserve and improve the quality of rural health care services, we are going to have to find new ways of motivating an adequate supply of professionals to serve where, at this time, they are needed the most--in financially depressed areas of rural America. We are going to have to address related problems ranging from the proper dissemination of technology in these underserved areas to assurances of adequate reimbursement for services rendered. Americans now take quality health care for granted, but they will not be able to do so in the future unless the policies that we set forth now are in keeping with the constantly changing conditions that exist in the health care industry.

Mr. Chairman, again, thank you for your good work in this area and witnesses, thank you for sharing your expertise with us.

Opening Statement

Senator Harry Reid

July 11, 1988 Hearing

"The Rural Health Care Challenge: Part 2: Rural Personnel"

Thank you, Mr. Chairman, for providing the members of this Committee with an opportunity to examine the current status of rural health care. I would also like to take this chance to extend my sincere thanks to the distinguished group of witnesses who are lending their valuable time and testimony.

I am anxious to hear today of the various staffing problems being encountered by rural health care providers in other states. Mr. Chairman, you have stated that there are severe shortages of doctors, nurses and other health care providers in rural areas, but that data specifying where these shortages are most severe is unavailable. Let me tell you, the shortages in Nevada are indeed severe.

I will be particularly interested to hear Dr. Hullett-Robertson's and Dr. Sundwall's testimony on their experiences with, and opinions of, the National Health Services Corps. Nevada is a state that in past years has greatly benefited from the use of Corps doctors. However, due to the decline in funding and participation in the program combined with the allocation decisions not going our way, we in Nevada are faced with the possibility of being granted the services of only one doctor 1989. In previous years we have been granted as many as 15. Nevada, and I am sure the other states represented here today, needs those Corps doctors. I hope we hear some encouraging news about the future of the Corps and the development of other innovative health personnel recruitment programs.

Mr. Chairman, I would like to once gain thank you for holding these two hearings on rural health care. We are lucky in Nevada to have some extremely talented people working to solve the problems we will hear of today. In fact, I would like to take this time to publicly thank and praise two such people who have been of tremendous help to me and my staff ---- Ms. Robin Keith, the project director for the Nevada Rural Hospital Project, and Ms. Caroline Ford, Director of the Office of Rural Health at the University of Nevada School of Medicine and Region 9 representative on the Board of Directors of the National Rural Health Association. These Nevadans are currently studying and working to solve a wide range of rural health care problems and I look forward to sharing their findings with this Committee in the future. Mr. Chairman, it is this sharing of experience, research, and innovation that you are permitting us to do here today that will bring us closer to solving the problems facing rural health care.

The CHAIRMAN. Senator Burdick, do you have an opening statement?

STATEMENT OF SENATOR QUENTIN BURDICK

Senator BURDICK. Yes, Mr. Chairman.

I want to thank you for holding this hearing on rural health care personnel. As Co-chairman of the Senate Rural Health Caucus, I am concerned about attracting well educated health care providers to rural areas.

This is particularly important for the one-third of our nation's elderly who live in rural areas. The elderly require more health services than other groups. With the numbers of rural elderly increasing, more demands will be placed on rural health care providers.

In addition to the special needs of the aged, there are other pressing health concerns affecting our rural population. Problems range from high infant mortality to a high incidence of teenage suicide and greater numbers of accidents.

These serious health concerns demand available and qualified health personnel. Yet, keeping an adequate supply of providers in rural areas is difficult.

It would be nice to think that the supply of health providers will be sufficient to meet the demand. However, my constituents in North Dakota tell me otherwise.

The fact is, Mr. Chairman, rural areas will continue to suffer shortages of physicians and other health care personnel. That makes Federal support for programs such as the National Health Service Corps all the more important.

We also need to address the need for mental health services. There are intermittent reports about suicide among the elderly. In addition, the drought is creating enormous stress in rural communities.

It is vitally important now that people have access to a range of mental health providers. Yet, in my State of North Dakota, there is an alarming decrease in the availability of providers such as psychologists.

Lack of mental health care providers isn't just a problem in North Dakota. The National Association of Social Workers surveyed six States. In five of the six, between 26 and 34 percent of the largely rural counties are served only by social workers. Neither psychologists nor psychiatrists are present in those counties.

Until Medicare reimburses social workers, nurse practitioners and others, consumer access to service will be blocked. Both recruitment and retention of rural health care providers must be priorities.

Last week, I introduced a bill along with my colleagues, Senator Grassley, Inouye, and others, S. 2597, which would help to address recruitment in rural areas. It would establish a rural focused training grant program for allied health professionals. This bill is specifically designed to attract a variety of providers to rural areas.

In addition to getting providers into rural areas, we also have a responsibility to help create an environment that encourages them to stay. In many cases, health care professionals are discouraged by heavy patient loads and outdated equipment. They often experience little financial reward.

Furthermore, rural practice often means professional isolation. A nurse practitioner may be the sole practitioner in a rural area, without the benefit of a group practice.

The stability of a rural practice can hinge on whether a provider has backup when needed. Choosing to remain in a rural area may depend on the availability of state of the art information and adequate resources.

I look forward to hearing the testimony that will be presented this morning. It should be very useful as we learn more about rural health care problems and ways the Federal Government can help address these concerns.

Thank you, Mr. Chairman.

The **Chairman**. Senator Grassley, do you have an opening statement?

STATEMENT OF SENATOR CHARLES GRASSLEY

Senator **Grassley**. Yes, Mr. Chairman, I do.

I want to say that I, like most everybody on this committee, and probably everybody who is in the United States Senate, am concerned about the growing problem of shortages of the number of health care professionals and allied health professionals practicing in rural America. The Iowa Hospital Association Data Center has provided me with some information about this problem as it exists in Iowa, and I am going to submit that for the record.

In Iowa, we had in 1986 a gain of 297 physicians starting new practices across all specialties. I know that sounds pretty good, but it sounds good until you consider the fact that we had 281 physicians cease practice through retirement, relocation, disability, or death. So, that was a net gain of 16 physicians.

In the year before that, 1986, my State had a net loss of 14 physicians. Prior to these last two years, there had been in Iowa a net gain of at least 75 physicians a year for eight consecutive years.

The situation is even worse, though, when one considers only family practitioners. In 1986, 82 new family practices were started in Iowa, but we had a loss of 108. So, we had a net loss of 16 family practitioners.

Two years of greatly reduced gains, or losses, in the number of physicians probably cannot be said to make a trend. Yet, it ought to be very disquieting for those of us concerned about this problem as we pursue to educate our colleagues about it.

I think you can see the consequences of these developments more clearly in the fact that, at the present time in Iowa, 160 communities are actively seeking a total of 250 physicians. Even though the Graduate Medical Education National Advisory Committee projects a national surplus of 62,000 physicians by 1990, those who follow these matters in Iowa think that the supply of Iowa physicians will be 1,000 to 2,000 fewer than the number we need.

We also appear to be facing a shortage of nurses in Iowa. I know that this is a matter for one of the hearings that you have had here at this committee, and we are hearing a good deal about it at the national level.

I understand that there is no consensus as to whether there is actually a national nursing shortage, but that lack of consensus has not influenced me in that, particularly as it relates to rural America, or at least with the distribution of those people in that profession, we have a shortage.

In Iowa, although there have been increases in the number of Bachelor of Science in nursing graduates over the last two years, there have been substantial decreases in the number of graduates in other types of nurse degree programs. Most of these lost graduates would have practiced in Iowa.

It is also disturbing to note that there have been decreases in the number of people enrolling in nursing programs in Iowa. Such declines in enrollment are going to translate in my State into shortages in the work settings in which we need nurses—hospitals, nursing homes, clinics, and doctors' offices.

Although we seem to hear most about the shortages of physicians and nurses in rural communities, we should not overlook the fact that our rural communities are experiencing shortages of physical therapists, X-ray and laboratory technologists, occupational therapists, and pharmacists.

I think most of us understand that many things affect the supply and demand for health care providers both nationwide and in rural areas. These are things such as the reimbursement patterns under Medicare, competing career opportunities for women, the demand for nurses in settings other than those in which direct health care is provided, and, of course, the economic downturn in recent years in some areas of the country, and that is particularly true in the upper Midwest and the agricultural areas of the country. These are all very powerful influences, and others can surely be mentioned.

I am not sure anyone knows exactly how to deal with this situation, Mr. Chairman. Hence, we thank you for your leadership as is demonstrated by holding this hearing.

Senator Burdick has already referred to a bill that he, Senator Inouye, and I have introduced for the purpose of attracting health and allied health professions into the rural communities. I don't think that any of us who sponsor this bill are under any illusions that this bill will make a very big dent in the problems we are discussing today, but we hope that it is going to help in a small way.

So, we are all looking forward to hearing and reviewing the testimony that we will take today and subsequent committee initiatives on this issue.

Mr. Chairman, that is all I have for the moment. Thank you.

[The prepared statement of Senator Grassley and information from the Iowa Hospital Association follow:]

STATEMENT BY SENATOR CHARLES E. GRASSLEY AT A SPECIAL COMMITTEE ON AGING HEARING ON RURAL HEALTH PERSONNEL, MONDAY, JULY 11, 1988

THANK YOU, MR. CHAIRMAN.

MANY OF US ARE CONCERNED ABOUT THE GROWING PROBLEM OF SHORTAGES IN THE NUMBER OF HEALTH CARE PROFESSONALS AND ALLIED HEALTH PROFESSIONALS PRACTICING IN RURAL COMMUNITIES.

THE IOWA HOSPITAL ASSOCIATION'S DATA CENTER HAS PROVIDED ME WITH SOME INFORMATION ABOUT THIS PROBLEM AS IT EXISTS IN IOWA, MR. CHAIRMAN, AND I WOULD LIKE TO SUBMIT SOME OF THIS MATERIAL FOR INCLUSION WITH THE HEARING RECORD.

IN IOWA WE HAD IN 1986 A GAIN OF 297 PHYSICIANS STARTING NEW PRACTICES ACROSS ALL SPECIALTIES. SOUNDS PRETTY GOOD, DOESN'T IT? IT SOUNDS GOOD UNTIL YOU CONSIDER THE FACT THAT 281 PHYSICIANS CEASED PRACTICE THROUGH RETIREMENT, RELOCATION, DISABILITY OR DEATH. SO, THE NET GAIN WAS 16 PHYSICIANS. IN THE YEAR BEFORE, 1985, MY STATE HAD A NET LOSS OF 14 PHYSICIANS. PRIOR TO THESE LAST TWO YEARS, THERE HAD BEEN IN IOWA A NET GAIN OF AT LEAST 75 PHYSICIANS A YEAR FOR 8 CONSECUTIVE YEARS.

THE SITUATION IS EVEN WORSE WHEN ONE CONSIDERS ONLY FAMILY PRACTITIONERS. IN 1986, 82 NEW FAMILY PRACTICES WERE STARTED IN IOWA.

BUT WE LOST 108. SO THERE WAS A LOSS OF 26 FAMILY PRACTITIONERS IN MY STATE. TWO YEARS OF GREATLY REDUCED GAINS, OR LOSSES, IN THE NUMBERS OF PHYSICIANS PROBABLY CANNOT BE SAID TO MAKE A TREND. YET, IT IS DISQUIETING.

I THINK YOU CAN SEE THE CONSEQUENCES OF THESE DEVELOPMENTS MORE CLEARLY IN THE FACT THAT, AT THE PRESENT TIME, IN IOWA, 160 COMMUNITIES ARE ACTIVELY SEEKING A TOTAL OF 250 PHYSICIANS.

EVEN THOUGH THE GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COMMITTEE PROJECTS A NATIONAL SURPLUS OF 62,000 PHYSICIANS BY 1990, THOSE WHO FOLLOW THESE MATTERS IN IOWA THINK THAT THE SUPPLY OF IOWA PHYSICIANS WILL BE ONE TO TWO THOUSAND FEWER THAN THE NUMBER WE NEED.

WE ALSO APPEAR TO BE FACING A SHORTAGE OF NURSES IN IOWA. THIS MATTER OF A NURSE SHORTAGE IS ONE WE ARE HEARING A GOOD DEAL ABOUT AT THE NATIONAL LEVEL ALSO. I UNDERSTAND THAT THERE IS NO CONSENSUS AS TO WHETHER THERE ACTUALLY IS A NATIONAL NURSE SHORTAGE. APPARENTLY, WE HAVE MORE NURSES AT THIS TIME THAN WE HAVE EVER BEFORE IN HISTORY. NEVERTHELESS, WE CERTAINLY SEEM TO BE HEARING FROM EVERY CORNER THAT THERE IS SUCH A SHORTAGE.

IN IOWA, ALTHOUGH THERE HAVE BEEN INCREASES IN THE NUMBERS OF BSN GRADUATES OVER THE LAST TWO YEARS, THERE HAVE BEEN SUBSTANTIAL DECREASES IN THE NUMBER OF GRADUATES IN OTHER TYPES OF NURSE DEGREE PROGRAMS. MOST OF THESE LOST GRADUATES WOULD HAVE PRACTICED IN IOWA.

IT IS ALSO DISTURBING TO NOTE THAT THERE HAVE BEEN DECREASES IN THE NUMBER OF PEOPLE ENROLLING IN NURSING PROGRAMS IN IOWA.

SUCH DECLINES IN ENROLLMENT WILL TRANSLATE IN MY STATE INTO SHORTAGES IN THE WORK SETTINGS IN WHICH WE NEED NURSES -- ---- HOSPITALS, NURSING HOMES, CLINICS, AND DOCTORS OFFICES.

ALTHOUGH WE SEEM TO HEAR MOST ABOUT THE SHORTAGES OF PHYSICIANS AND NURSES IN RURAL COMMUNITIES, WE SHOULD NOT OVERLOOK THE FACT THAT OUR RURAL COMMUNITIES ARE EXPERIENCING SHORTAGES OF PHYSICAL THERAPISTS, X-RAY AND LABORATORY TECHNOLOGISTS, OCCUPATIONAL THERAPISTS AND PHARMACISTS.

I THINK MOST OF US UNDERSTAND THAT MANY THINGS AFFECT THE SUPPLY AND DEMAND FOR HEALTH CARE PROVIDERS BOTH NATIONWIDE AND IN RURAL AREAS. THESE ARE THINGS SUCH AS REIMBURSEMENT PATTERNS UNDER MEDICARE, COMPETING CAREER OPPORTUNITIES FOR WOMEN, THE DEMAND FOR NURSES IN SETTINGS OTHER THAN THOSE IN WHICH DIRECT HEALTH CARE IS PROVIDED, AND THE ECONOMIC DOWNTURN OF RECENT YEARS IN SOME AREAS OF THE COUNTRY. THESE ARE POWERFUL INFLUENCES. OTHERS SURELY COULD BE MENTIONED.

I'M NOT SURE ANYONE KNOWS EXACTLY HOW TO DEAL WITH THIS SITUATION, MR. CHAIRMAN. AS YOU MAY KNOW, MY COLLEAGUES SENATORS BURDICK AND INNOUYE AND I HAVE INTRODUCED A BILL THE PURPOSE OF WHICH IS TO ATTRACT HEALTH AND ALLIED HEALTH PROFESSIONALS INTO RURAL COMMUNITIES. I DON'T THINK WE ARE UNDER ANY ILLUSIONS THAT THAT BILL WILL MAKE A VERY BIG DENT IN THE PROBLEM WE ARE DISCUSSING TODAY -- BUT IT MIGHT HELP IN A SMALL WAY.

I AM LOOKING FORWARD TO HEARING OR REVIEWING THE TESTIMONY WE WILL TAKE TODAY, AND TO SUBSEQUENT COMMITTEE INITIATIVES ON THIS ISSUE.

THANK YOU, MR. CHAIRMAN. THAT IS ALL I HAVE FOR THE MOMENT.

THE IOWA HOSPITAL ASSOCIATION
100 East Grand • Des Moines, Iowa 50309 • Phone (515) 288-1955
DONALD W. DUNN, President

RURAL HEALTH CARE FORUM
NORTH IOWA AREA COMMUNITY COLLEGE
MASON CITY, IOWA

June 13, 1988

by

Jon L. Jensen
Executive Vice President
Iowa Hospital Association

PROFESSIONAL MANPOWER SHORTAGE IN RURAL AREAS

I am pleased to come before you as Executive Vice President of the Iowa Hospital Association and its 127 not-for-profit member institutions, all of which serve rural populations of Iowa; 98 of which have less than 100 acute care beds and are located in nonmetropolitan areas.

There are unique health manpower problems in rural Iowa:

— This audience knows the challenge it is to recruit and retain physicians, nurses, and allied health professionals in rural Iowa.

— This audience is aware of the maldistribution of most health professionals.

-- This audience is aware that rural hospitals and rural physicians are compensated at lower rates, making physician recruitment more difficult and retention of other health professionals more challenging.

Rural America has 33 percent of the population, but only 12 percent of the physicians and only 18 percent of the nurses.

The shortage of health professionals is complicated by the fact that there are unique health care needs in rural America:

— The population is older and the percentage of elderly is growing.

— It is estimated that 60 percent of the nation's 49 million medically underserved live in rural America.

-- The population in rural America is more sparse, making access to health care difficult.

The United States spends 42 percent fewer health service dollars per capita in rural areas than nationwide. Small rural communities have physician to population ratios less than one-third the national average—53 physicians per 100,000 people, compared with 163 physicians per 100,000 nationally.

In spite of this obvious need, funding for the National Health Service Corps which places doctors in rural areas has steadily declined. The budget for the Corps Field Replacement Program dropped from $95 million in 1982 to $37 million in 1987. After 17 years of existence, the National Health Service Corps has yet to realize its potential of bringing physicians to health manpower shortage areas which now number 1,942. The National Health Service Corps is eliminated each year in the Administration's budget but so far has been revived by the Congress.

— Robert Van Hook in the October 1987 issue of MEDICAL WORLD NEWS suggests that many physicians see a significant disincentive to practice out in the country because of inappropriate and inequitable Medicare reimbursement. He states, "The physician payment differential is a frightening disparity, in some cases running as much as 60 percent less than what an urban or suburban doctor would be reimbursed. And yet the cost of providing care can actually be higher in rural areas in part because of higher overhead costs and higher malpractice insurance premiums. Recruitment and retention of physicians is a major problem for rural hospitals. Particularly difficult to attract are obstetricians and emergency physicians."

I am sure that Dr. Seebohm and Dr. Trimble will provide more specificity on the Iowa physician shortage in their comments. I believe they will agree that the Graduate Medical Education National Advisory Committee's projected surplus of 62,000 physicians by 1990 will not materialize in Iowa; and that, in fact, by 1990 the supply of Iowa physicians will be one or two thousand fewer than the number the state needs. The Iowa shortfall will include an estimated 600 primary care physicians who provide the sole source of primary medical care in over half of Iowa's 99 counties.

Roger Tracy of the University of Iowa College of Medicine reports that at the present time more than 150 Iowa communities are actively recruiting physicians to serve their community needs. In spite of the excellent University of Iowa Family Practice Program, the number of family physicians in Iowa actually declined by 22 in 1985.

— An article by Schwartz, Sloan and Mendelson in the April 7th issue of NEW ENGLAND JOURNAL OF MEDICINE also contradicts the predicted national physician surplus and suggests that after accounting for an increasing demand for physicians in administrative and research positions, changes in resident's work patterns and the increasing number of woman physicians, by the year 2000 there will be 7000 fewer physicians than we need.

One of the major factors accounting for inequitable distribution of physicians in rural areas is the payment factor. Rural hospitals are penalized by being paid $1500 or $2000 less, for example, to treat a patient with pneumonia than their urban counterpart hospital. A rural doctor living outside of the standard metropolitan areas gets paid about half the fee that Medicare pays a doctor with similar training for delivering the same service in an urban area.

The nursing shortage is back again. Just five years ago when DRGs first began, there was actually a surplus of nurses, and layoffs were occurring throughout Iowa. In 1984, while serving as administrator of a rural hospital, Jackson County Hospital in Maquoketa, the daughter of our director of nursing graduated from nursing school. We were unable to place her on our staff as were hospitals in Dubuque, Davenport and Cedar Rapids. She ended up going to Florida to find a job. Four short years later the crisis is upon us. Someone suggested it returns like the seven-year locust.

The last time we had a critical shortage of nurses was in the late seventies or early eighties. Symptoms of the crisis of 1988 are similar—high turnover, job dissatisfaction with nursing as a profession, and the resulting shortage of available candidates for vacancies.

— A 1987 publication by the American Hospital Association entitled "Strategies for Recruitment and Retention of Hospital Nurses" reports that enrollments in all types of RN education programs dropped 13 percent between 1983 and 1985. These declines have continued. The publication notes that by the year 2000 the demand for baccalaureate-prepared RNs will be twice the available supply. The publication reported that 80 percent of the hospitals surveyed reported nursing vacancies. Also observed was that federal funding for nursing education in 1987 was one-third of what it was in 1973.

— A May 12, 1988 news release from the American Hospital Association reports three out of four hospitals relied on overtime for nursing staff, and 41 percent employed temporary or agency nurses. Unfortunately, there is not only a shortage of nurses but demand is greater than ever before. Hospitals have reduced the number of full-time equivalent employees (about 100,000 fewer than they had five years ago). However, they employ almost 40,000 more nurses because the more severely ill patients require highly skilled nursing care.

— The May 31, 1988 NEW YORK TIMES suggests that the nursing shortage is adding billions of dollars to the nation's health care bill. Examples:

(1) In Boston, employment agencies charge hospitals 8 to 10 thousand for each nurse hired.

(2) Southern California hospitals are paying the equivalent of $85,000 a year for temporary nurses provided by employment services or temporary manpower agencies.

(3) In New York, nurses recently signed contracts raising starting salaries to $29,000. The national average is $22,000.

— A 1987 AHA publication entitled "The Nursing Shortage Facts Figures and Feelings" reports that vacancies in nursing as of December 1, 1986 were approximately 13.6 percent of the RN full-time equivalent positions.

— An Iowa survey conducted by the Iowa Organization of Nurse Executives in January 1988 reported 481 vacancies in Iowa. The RN vacancy rate statewide averages 8.61 percent.

— A recent AHA survey of nursing shortage published in AHA NEWS suggested that the nursing shortage worsened in 1987. More than 78 percent of hospitals responding to a survey reported a nursing shortage.

— A recent Associated Press news release from the American Nurses Association suggests 300,000 nursing vacancies nationwide with hospital nursing vacancies nearing 20 percent.

The shortage of other health care professionals has also reached critical dimensions, particularly in rural areas. Physical therapists, pharmacists, respiratory therapists, X-ray and lab technologists, occupational therapists, and other health care professions are in short supply.

— The National Bureau of Labor Statistics suggests that there are 60,500 physical therapists available in the United States with approximately 3900 new graduates annually. However, attrition and the creation of new positions result in a deficit of approximately 1500 annually.

— The University of Iowa Program in Physical Therapy graduates only 30 physical therapists a year and over half of that graduating class locates in other states.

— This year the University of Osteopathic Medicine and Science has begun a class in physical therapy and will graduate its first students in 1989 or 1990. Hopefully some will stay in Iowa.

I do not have data available on the number of vacancies in physical therapy, but based on the inquiries received at the Iowa Hospital Association offices, I conclude that the entire graduating class from the University of Iowa could be absorbed by Iowa hospitals at any time.

Shortages also exist—particularly in rural hospitals—for X-ray, and laboratory technologists and occupational therapists. Occupational therapists are required for hospitals that are involved in home health care programs and rehabilitation and skilled nursing programs. The shortage of X-ray technologists seems to be a lack of students. Nationally, programs have a student capacity of 26,500, but only 15,000 actually enrolled, or a 56 percent occupancy. Occupational therapy, another major shortage group, had 1395 student vacancies in accredited programs.

The shortage of physicians, nurses, physical therapists, pharmacists, and other professionals is acute in rural areas. The rural hospital has difficulty recruiting and retaining professionals because of the inequity of Medicare payment and the difficulty of attracting professionals to isolated rural areas.

I have already commented in more detail than is necessary in light of the other experts on the panel who will address specific areas.

Let me close with some suggested directions for addressing health manpower concerns.

Physician shortages in rural areas could be significantly relieved by correcting Medicare payment inequities. We can't continue to financially penalize the doctor for locating in a rural underserved area.

Shortages of physical therapists, occupational therapists and technologists would be somewhat alleviated by salary improvement which could be accomplished if rural hospitals were adequately reimbursed. In addition, hospitals, IHA and AHA need to become actively involved in public relations programs to promote health careers.

Solutions to the nursing crisis are more involved but could include:

(1) Salary increases. The last nursing shortage in 1979 and 1980 was alleviated when nurse salaries were raised an average of 13 percent. Solution to the current shortage is not that simple. I think it will last for several years rather than one, because of other changes in the health care field, but one of the solutions is increasing salaries for nurses. We should provide adequate and equitable Medicare reimbursement so that rural hospitals can pay competitive salaries.

(2) Extension of the temporary H-1 visas currently held by approximately 10,000 foreign nurses working in this country. We are not in a position to give up that supply of nurses now and hopefully the Commissioner of Immigration Service will agree to extend for at least one year those temporary visas to help alleviate the severe shortage of nurses, particularly in the California and New York areas but impacting all states.

(3) We should extend federal funding and financial aid for entry level nursing education in order that we might attract and maintain qualified students in both hospital-based diploma programs and college-based BSN programs.

(4) We should target funds to support the educational ladder or mobility for licensed practical nurses. Programs to enable licensed practical nurses to obtain RN degrees would help us to meet both short- and long-range shortages.

(5) We should conduct studies of successful programs for improved nurse retention within the health care environment and particularly among hospitals.

(6) We could increase public funding for advanced nurses training to allow the diploma nurse to receive a BSN degree.

(7) Finally, hospitals should study the use of additional technology to reduce the number of nursing hours required in order to use existing staff more efficiently. There are computer systems such as CliniCom, Health Data Sciences, and Micro Health Systems which provide computerized bedside systems to eliminate a lot of nursing paper work as well as potential errors. A study at St. Francis Hospital in Topeka, Kansas using the CliniCom system demonstrated fewer staff members were needed to care for 29 percent more patients. Time spent in incident processing was reduced 50 percent. Methodist Hospital in Brooklyn, using a similar system called MedTake, established a savings of between 45 minutes and 2 hours per nursing shift using this computerized system resulting in elimination of overtime, and a higher patient/nurse ratio. We should look at new technology as another possible way to reduce nursing man hours and therefore staffing.

Thank you for the opportunity to present these concerns.

July 21, 1988

The **Chairman**. Thank you.

Our first witness this morning is Dr. Sandral Hullett from Eutaw, Alabama.

Dr. Hullett, I think we have the Senator from Alabama who would like to introduce you to the committee.

Senator Shelby.

STATEMENT OF SENATOR RICHARD SHELBY

Senator **Shelby**. Thank you, Mr. Chairman.

I believe I am still on central time coming out of the South, but it is my privilege to be here today with you, Mr. Chairman, and I commend you for calling this hearing.

I have a written statement that I want to ask unanimous consent to be made part of the record.

The **Chairman**. Without objection, it will be made part of the record at this point.

[The prepared statement of Senator Shelby follows:]

Shelby

SPECIAL COMMITTEE ON AGING
JULY 11, 1988
THE RURAL HEALTH CARE CHALLENGE: PART 2: RURAL HEALTH CARE PERSONNEL

THANK YOU MR. CHAIRMAN. I WILL KEEP MY COMMENTS BRIEF THIS MORNING BECAUSE I AM ANXIOUS TO HEAR FROM THE DISTINGUISHED PANEL OF WITNESSES ASSEMBLED FOR THIS HEARING. I WOULD ESPECIALLY LIKE TO WELCOME DR. HULLETT-ROBERTSON, FROM MY HOME STATE OF ALABAMA, TO THIS COMMITTEE AND TO CONGRATULATE HER ON BEING NAMED "RURAL HEALTH PRACTITIONER OF THE YEAR." DOCTOR, I COMMEND YOU ON THE WORK YOU ARE DOING IN YOUR COMMUNITY, AND AM LOOKING FORWARD TO YOUR TESTIMONY.

I BELIEVE THAT WE ARE ALL FAMILIAR WITH THE PLETHORA OF PROBLEMS FACING OUR RURAL HEALTH CARE DELIVERY SYSTEM. LAST MONTH, THIS COMMITTEE HEARD FROM SEVERAL WITNESSES ABOUT THE CRISIS FACING OUR RURAL HOSPITALS. IN ALABAMA, IT IS ESTIMATED THAT AS MANY AS TEN HOSPITALS WILL BE FORCED TO CLOSE THIS YEAR, AND ALL ARE LOCATED IN RURAL AREAS. AS MORE RURAL HOSPITALS CLOSE THEIR DOORS, THE COMMUNITY WILL OFTEN LOSE ITS PHYSICIANS, AND HAS DIFFICULTY ATTRACTING NEW ONES BECAUSE OFTEN DOCTORS ARE RELUCTANT TO PRACTICE IN AN AREA WITHOUT A HOSPITAL. HOWEVER, THE PROBLEM DOES NOT STOP HERE.

RURAL PRACTITIONERS FACE OTHER DIFFICULTIES. THEY TREAT A HIGHER PROPORTION OF ELDERLY AND FRAIL PATIENTS. ONE THIRD OF OUR NATION'S ELDERLY LIVE IN RURAL AREAS, AND RURAL PRACTITIONERS OFTEN TREAT PATIENTS WHO ARE SICKER, AS IT IS REPORTED THAT RURAL AMERICANS HAVE DISPROPORTIONATELY HIGHER RATES OF SERIOUS CHRONIC ILLNESS. ALSO, RURAL CITIZENS ARE MORE LIKELY TO LACK INSURANCE, AND AS MANY 75 PERCENT OF THE RURAL POOR DO NOT QUALIFY FOR PUBLIC ASSISTANCE. THUS, RURAL PRACTITIONERS ARE MORE DEPENDENT UPON MEDICARE AND MEDICAID, YET ARE REIMBURSED AT LOWER RATES -- AN INEQUITY THAT THIS SENATOR WOULD LIKE TO SEE CORRECTED.

CITIZENS IN RURAL AMERICA ARE OFTEN DENIED ACCESS TO QUALITY HEALTH CARE SIMPLY BECAUSE THE AREA MAY NOT HAVE AN ADEQUATE NUMBER OF HEALTH CARE PROFESSIONALS. IN MY HOME STATE OF ALABAMA, INFANT MORTALITY IS A PROBLEM WHICH IS OFTEN ASSOCIATED WITH LACK OF ADEQUATE AND AVAILABLE PRENATAL CARE SERVICES. MANY PREGNANT WOMEN SEE THE DOCTOR FOR THE FIRST TIME AT THE POINT OF DELIVERY.

IT IS IMPERATIVE THAT RURAL AMERICANS BE AFFORDED THE SAME ACCESS TO QUALITY HEALTH CARE SERVICES AS THEIR URBAN COUNTERPARTS. I LOOK FORWARD TO HEARING FROM OUR WITNESSES THIS MORNING ON WAYS TO ENSURE THAT THIS COMMITMENT TO OUR RURAL CITIZENS IS KEPT.

Senator **Shelby**. Mr. Chairman, I would especially like to welcome Dr. Hullett-Robertson from my home State of Alabama to this committee and to congratulate her on being named Rural Health Practitioner of the Year.

Doctor, I commend you on the work you are doing in your community in my State, and I am looking forward to your testimony here today.

Thank you, Mr. Chairman.

The **Chairman**. Thank you.

Please proceed, Doctor.

STATEMENT OF SANDRAL HULLETT-ROBERTSON, M.D., DIRECTOR, WEST ALABAMA HEALTH SERVICES, EUTAW, AL

Dr. **Hullett**. Mr. Chairman and other Senators—I was glad to see Senator Shelby come in—I am pleased to share with you today why I continue to work in a rural community. I am also pleased to discuss the difficulties of maintaining a rural practice and to give my views on how health care personnel shortages in rural areas could be alleviated.

I first would like to let you know a little bit about the area where I work. This area is known as the Black Belt. It is referred to as the Black Belt not because of the population but because of the soil.

It has a wide band of black soil that goes through a large section of the State. This area was once one of the richest cotton producing areas in the country, not just in Alabama but in the country.

Presently, things have changed. Cotton is no longer king, the area now is extremely poor. In fact, two of the counties in this area have the lowest per capita income in the nation with an annual income of $5,548 a year for a family of four.

The infant mortality is the highest in the nation. The elderly population is greater than 35 percent which increases the demands and uses of health care. Within the area, 30 percent of all families are at the poverty level, with a minority population of 61 percent. Only 67 percent of the population has telephones, and another 67 percent have working transportation.

The physician to patient ratio ranges from 1 to 1,300. However, in some of our counties, there are 4 full-time physicians in a county with 18,000 persons. Specialty care for most medical problems is not available unless one travels up to 100 miles away.

My practice is a general practice, including pediatrics as well as geriatrics. We like to say from the cradle to the grave.

I continue to deliver obstetrical care during these difficult times of malpractice and can only afford to do so because my premiums are paid by the agency for which I work. I serve as the health services director of the West Alabama Health Services in Green County which is a community health center funded under the 330 programs.

This allows me to look at not only hands-on health care delivery but also health care delivery systems and to face the problems of obtaining health care personnel. Physicians have been placed in our area, primarily, for the last 10 years, through the National Health Service Corps. I came as a National Health Service Corps assignee with a two-year obligation and reenlisted as a volunteer for another two years.

I am now a contracted physician and now entering my tenth year in my original site. We have only been able to contract two physicians who were not in the National Health Service Corps. One was a foreign medical graduate, and one was about to go into bankruptcy serving the very poor.

I have worked alone in my sites sometimes for as long as two years, averaging 60 or more patients a day, doing night call, hospital practice, and OB services ranging from 10 to 15 babies a month. Many rural physicians continue to perform at this pace, but this is not desirable. An excellent support staff enables me to meet this challenge, but this type of practice for years would be something even I would not continue.

The workload is great in rural communities. Our agency has grown, but also the number of patients has grown, and the needs have increased. The responsibility for this is due to the large number of working poor, increased demands for OB care, and, in our area, nearly all the family practitioners are no longer delivering OB care, and this is due to the malpractice crisis. Malpractice is a crisis in our area.

There is also an increased demand for the use of health care by our ever increasing elderly population.

Although I have been able to obtain excellent National Health Service Corps physicians, nurses, nurse practitioners, and other allied health care personnel are almost unattainable.

There are several areas one must be aware of in looking for small towns and communities in which to practice. They are community governence, cultural relevance, outreach, and how to transfer knowledge and skills and commitment.

I have found that understanding these principles aid the practice of medicine, and I have become effective in my practice and community, because I understand that personality and commitment alone cannot make a program. Rather, work in cooperation with the community, being aware of their needs, flexibility, and the addition of commitment and personality contribute to a program.

Commitment and dedication will always exist. However, more medical students and other allied health professional students should become exposed to people who are committed and dedicated to refurbish the sparks.

The American Medical Student Association is attempting such programs. First and second year medical students are offered opportunities to spend summers with primary care physicians to develop health prevention and promotion projects. I think that is something that is good and may help in getting more physicians.

The difficulties are many but do not overpower the positives of working in small towns. Some difficulties are losing good providers and recruiting new ones, low salaries for staff, maintaining quality hospital facilities to work in, a lack of funding to develop career enhancement programs for staff and community people.

The following are some of my thoughts on ways to alleviate personnel shortages:

Continue and increase the assignment of National Health Service Corps assignees in rural communities.

Continue and increase support for minorities in health professions. As I stated earlier, the area that I work in is 61 percent minorities, and in some areas, it is as high as 75 percent. Yet, I was one of the first women and blacks to work in that area.

Continue support to community health centers, migrant farmer programs, and Indian health services.

Additional funding to improve rural transportation programs is needed.

Encourage the funding of university and training programs to link with small towns and rural communities to share resources and services.

To conclude, I wish to thank the Federal Government for the present programs which aid the practicing physicians in underserved areas such as community health centers and the National Health Service Corps. I am requesting continuation of the National Health Service programs and broadening the scope to include not only physicians but nurses, social workers, nutritionists, and a full array of professionals to shortage areas.

There were two physicians who were talking about National Health Service Corps assignees. One really didn't think the National Health Service Corps assignees really made that big a difference. He said they leave. These young people leave; they don't do us any good.

The other physician said, well, I disagree. If they stay with us only for one year, that helps share the load, and I live a little bit longer.

I would like to conclude my testimony, and I am open for any questions that you would like to ask.

[The prepared statement of Dr. Hullett follows:]

Testimony of
Sandral Hullett, MD, MPH
To The
Senate Special Committee on Aging
Part 2: Rural Health Personnel

July 11, 1988

I am Sandral Hullett, a rural health physician with a speciality in family medicine from Eutaw, Alabama. This year I had the honor to be named Rural Health Practitioner of the Year by The National Rural Health Association. This by no means make me an expert on health personnel but does enable me to share with you today why I continue to practice in a rural community. I am pleased to also discuss the difficulties of maintaining a rural practice and my views on how health care personnel shortages in rural areas could be alleviated.

Background and Demographics

Why people select one area to live and work is as different as there are people, yet some common trends are present.

I was born in a metro area, Birmingham, Alabama and have worked and trained in cities. However, there were two early rural experiences which may have influenced my life: 1). both of my parents are from rural farm areas in Alabama and those early visits were pleasant, and 2). the first job I had teaching General Science in Coosa County, Alabama was probably the strongest of the two. This was an extremely remote community which had a dormitory built for teachers aross the street from the school. Teachers worked during the week and left on weekends. On evenings after the last school bus left, one could hear nothing, not even the sound of birds.

A child in one of my classes was bitten by a snake while fishing. He had to walk home with the other children assisting him over two miles. Once home, his mother had to find a ride to take him to the doctor who was over forty-five (45) miles away. The family did not have a phone, so the mother had to walk another mile and a half to the nearest phone and finally located someone to get the child to the doctor. The child lived, thank God, but lost the leg on which he received the bite.

The incident remained with me and still does. I decided if I went back to school, I would return to a community where I was needed.

After the year of teaching General Science, I left for New York and worked at Columbia Presbyterian Hospital Institute of Cancer Research as a Lab Assistant. Later I attended the Medical College of Pennsylvania in

Philadelphia. After borrowing what I could and needing further financial assistance, I had the option of joining the Army or the National Health Services Corps, in that I could work in Alabama (which at that time 1974, had 47 counties out of 67 on the medically underserved list).

After completion of my residency, I chose West Alabama Health Services, a community health center funded under 330 programs to fulfill my two year obligation.

This area is referred to as the Black Belt because of a wide area of rich black soil which passes through the area. This was one of the richest cotton producing areas in the county. Presently, employment availability consists of some agriculture, forest products, governmental housing units, textile and catfish farming jobs and there is an unemployment rate of 11% area wide. The Black Belt area is extremely poor and has two counties with the lowest per capita income area in the nation with an annual income of $5548.00/year for a family of four (4), infant mortality is highest in the state, the elderly population increases the demands and usage for health care. Within the area 30% of all families are at poverty level with a minority population of 61.28%. Only 67% of the population have telephones and another 67% have working transportation. The transportation percentage is even lower if one considers the car goes to work and if problems occur at home during working hours the family must wait until the car returns. The ratio of physician to patients in the area is 1 to 1335. Speciality care for most medical problems is not available unless travel is made to an urban area up to 100 miles away.

Two very important factors have increased the delivery of health care to this type of service area and they are; Community Health Centers and the National Health Service Corps.

Community Health Centers help by delivering quality medical and dental services with full support and staffing. The center for which I am Health Services Director, delivers care to five Black Belt counties. In order to staff these centers, we receive NHSC doctors. I came to this area as stated earlier as a NHSC enrollee in which time I served two years and re-enlisted two years. I am now a salaried physician, going into my tenth year.

I must admit it has been difficult to keep NHSC physicians past their obligation, but this has not been all bad. In an area as described, all health care providers are pleased to have Corps assignees if only for the designated period. They aid in delivering health care and although we sometimes do not like to admit it, we learn new techniques and information from them. Recruitment and retention are constant problems. Some advocate getting people from the community and training them for Bio-medical programs. Others state that Special Programs with benefits as an incentive to retain people in the area is the way to go. I think you need both concepts. We are now observing a Special Program funded originally by the Macy Foundation where students from the community are assisted by the University of Alabama to prepare for careers in health sciences. The program is now in the fifth year and we must wait to see how many will return to their respective communities.

I continue to practice in rural Alabama, because I love the patients, I enjoy a challenge, and I like to be needed.

The difficulties are many, but do not over power the positives. Some difficulties are loosing good providers and recruiting new ones, low salaries for staff, maintaining quality hospital facilities to work in, the lack of funding to develop career enhancement programs for staff and community people.

The following are some thoughts on how some of these shortages can be alleviated:

1). Continue and increase the assignment of National Health Services Corps assignees to rural communities.

2). Continue and increase support for minorities in the health professions.

3). Continue support to Community Health Centers, Migrant Farm Programs, and the Indian Health Services.

4). Additional funding to improve rural transportation programs.

5). Encourage through funding, universities and training programs to link with small towns and rural communities to share resources and services.

To conclude. I wish to thank the Federal Government for the present programs which aid the practicing physicians in underserved areas such as Community Health Centers and the National Health Service Corps.

I am requesting continuation of the National Health Services Programs and broadening of the scope to include not only physicians, but nurses, social workers , nutritionists and the full array of health professionals to shortage areas.

I was told of two physicians discussing NHSC assignees. One was not sure if it was the way to solve the problem especially in that these young people do not stay; the other physician replied, well they have done something for me, I live longer every time one comes.

The work is great and the laborers are few.

Thank you.

Senator **Burdick** (acting chairman). Dr. Hullett, you stated that the National Health Service Corps should fund not only physicians but other health care providers as well. I certainly agree. The Corps should be awarding loans and scholarships to nurses, social workers, and other health professionals.

You mentioned how hard it is to keep National Health Corps physicians in rural areas after they complete their obligation. Do you have any ideas about how we can address keeping Corps physicians in rural areas after they have met their obligations?

Dr. **Hullett**. One thing is many young people are placed in areas where they don't want to go. Alabama is in the Region IV area. Region IV has one of the largest needs for physicians because of the type of areas, the rural and poor areas.

When placing physicians in areas like this, we often overlook whether there is support for the physicians, school systems, jobs for spouses, etc. This is a problem which cannot be addressed by the Federal Government in all instances, but there should be some thoughts to place assignees in compatible sites.

I think this is (lack of compatibility) primarily one of the reasons we lose many of the assignees. Another concern is the reimbursement part.

You are sent to a place to work where you don't make very much money on a Corps salary, and when the obligation is over, the people in the area cannot afford to pay you for the type of work that you have to do. So, there aren't very many people willing to work long hours for very little pay. That is another way, increasing the reimbursement.

Senator **Burdick**. You say the universities should be encouraged to work with rural communities to share resources and services. I would like you to know that the bill that I mentioned in my opening remarks will encourage that kind of partnership and provide incentives to schools to give students experience in rural areas.

From your perspective as a health care provider, what are some of the benefits you think might occur as a result of university and rural community linkages?

Dr. **Hullett**. To me, that is one of the most exciting things that we are looking at right now with the University of Alabama and the School of Allied Health Services in Birmingham.

We are working to develop one of the old circuit rider systems, and that is if you have a consortium of people, if you have personnel that work well—a physical therapist, for example. You may have a master's level physical therapist or someone highly trained and then have two-year program people based at each site, and you can circuit ride to supervise.

The university is helping us to develop such a program. This is to give a valuable service to six rural communities with county hospitals. This is the type of thing your bill would aid and things we are working toward doing.

Senator **Burdick**. This may not be pertinent, but does Alabama still have a football team?

Senator **Shelby**. Mr. Chairman, if you would yield, we have one, but I think it is at Auburn.

Dr. **Hullett**. The university still has a very good football team.

Senator **Burdick**. Senator Grassley.

Senator GRASSLEY. Thank you, Mr. Chairman.

I have a couple of short questions dealing with your ability to get people from the National Health Service Corps, physicians from that Corps. You noted that you had had difficulty keeping physicians past their initial obligation period.

What about the problem of getting them to accept the assignment in your clinic in the first place? Has that been a problem?

Dr. HULLETT. We did have problems earlier because of just the sheer number that were available. However, at the present time, the number is higher but is decreasing.

So, one of the things about our particular center is that we attract very good people. We have very energetic and dynamic people on the staff. We do a lot of things. So, we offer a very good experience.

Presently, we are not having trouble attracting internists and family practitioners. We are having trouble attracting obstetricians.

Senator GRASSLEY. Then, maybe my question on the law recently enacted in 1987 may not be quite appropriate for your situation, but I want your opinion on that anyway, and that is on the new loan forgiveness program that was enacted in 1987. That program signs up physicians at the end rather than at the beginning of their training.

Will this work better than this type of repayment program that we are presently working with?

Dr. HULLETT. I think it will. I sort of wish I had had that at that time, but I think it really would work. There are still quite a few people that—I think it would work.

Senator GRASSLEY. And you are saying, then, that it would work better than what we have today where——

Dr. HULLETT. As well.

Senator GRASSLEY. As well?

Dr. HULLETT. As well. Okay.

Senator GRASSLEY. Mr. Chairman, that is all the questions I have of this witness.

Senator BURDICK. Senator Shelby.

Senator SHELBY. Thank you, Mr. Chairman.

Dr. Hullett, I personally appreciate your being here, but more than that, since you went to medical school at the Medical College of Pennsylvania and Senator Heinz is here and was the former chairman of this committee, I want to thank them for giving you that medical education and then not keeping you and letting you come home, because we need you at home.

I am very concerned, Dr. Hullett, as you are, of what is going on in the area of infant mortality all over the nation but, particularly, in Alabama. You practice in an area—Green County, Eutaw, Alabama—that, as you mentioned, has one of the highest infant mortality statistics around.

What can we do to help you in the area of medical care other than reissuing and improving these programs, including nutrition programs, to alleviate some of that problem? Would you like to comment on that?

Dr. HULLETT. One of the things that we are hoping to aid us significantly is the SOBRA program. We are very excited and working towards setting it up now. In fact, the waivers have already been issued, and we are hoping to start the program as of August 1.

We hope to see some significant improvement with SOBRA. Again, we do need more obstetricians in the State. If we could get assistance in that way, that would help us also.

Senator SHELBY. What about nutrition, too?

Dr. HULLETT. Nutrition is an important part. The WIC program right now is working very well, and the eligibility has been expanded which is also a great help to the area.

If nutritionists were a part of this funding program that we could have more direct community participation and that would aid significantly.

Senator SHELBY. Doctor, does the area you described, the Black Belt of Alabama, have one of the highest infant mortality rates in the nation?

Dr. HULLETT. It is one of the highest in the State. Remember that Alabama last year had the highest infant mortality as a State, second only to the District of Columbia. This year has changed and we have fallen after aggressively working as a State-wide project—I think we are about tenth now.

Senator SHELBY. Is that because we dropped from 13 per 1,000 to 12.2 per 1,000?

Dr. HULLETT. Yes.

Senator SHELBY. But we are still up there, aren't we?

Dr. HULLETT. We are still very high. So, we are working on many different programs to try to combat this problem. Some of them are model programs. There is one in particular that I would like to speak to briefly.

It is using lay women in the community to address the problem of infant mortality. Women in the community, paid minimum salaries, go out and meet and talk to young mothers to encourage them to come in for health care. We think this is a most cost effective way of delivering care during a time when we no longer have nurse midwives and lay midwives. So, this is a new model program that we think should work.

Senator SHELBY. Doctor, do you know of any better program dealing in health prevention like this that would not only save lives but would save money?

Dr. HULLETT. The one I just described, I think, is an excellent one. It is low cost and can help save lives.

Senator SHELBY. And high yield, high return.

Dr. HULLETT. High return.

Senator SHELBY. Thank you for appearing before the committee here.

Dr. HULLETT. Thank you.

Senator SHELBY. Thank you, Mr. Chairman.

Senator BURDICK. Thank you.

Senator Durenberger.

STATEMENT OF SENATOR DAVE DURENBERGER

Senator DURENBERGER. Thank you, Mr. Chairman.

Dr. Hullett, could you summarize for me in following up on Dick Shelby's question which is terribly important—do you see the problem being one principally of financial resources or human resources?

Dr. HULLETT. Infant mortality?

Senator DURENBERGER. Yes, dealing with infant mortality.

Dr. HULLETT. I really see it as a socioeconomic problem. If we look across the board at not only minority people but at poor people as a whole, we see infant mortality higher. And minorities fall into the lowest of the socioeconomic group. So, we see an increase there.

I really think it is a socioeconomic problem.

Senator DURENBERGER. So, it isn't just a matter of having adequate medical services. A lot of it is education, isn't it?

Dr. HULLETT. Having adequate medical services and access to health care is important. It is extremely important. I won't belittle that at all.

But it is also an educational problem, too. But if you don't have the resources in the community that address the people where they are on the level that they are, then all the information that you have won't get anywhere. That is why I am very excited about using people in the community to help bring the message to get people in to follow up on the health care.

Senator DURENBERGER. We could say that a lack of obstetricians or even primary family practice physicians who were willing to do obstetrics could be part of the problem. Yet, there seem to be plenty of them around. They just don't seem to be willing, in some cases, to be where you want them or, because of the malpractice problems that we know so much about, are just unwilling to run the risk.

But even if we could attract them and reward them properly, what I hear you saying is that the problem in rural areas in particular of infant mortality is a much larger community problem that doesn't have to cost a whole lot of money, but it does have to get other kinds of personnel and other kinds of human resources committed to ending this incredible set of U.S. statistics.

Dr. HULLETT. Right. It takes the whole sphere. It is the whole thing. You need the provider to delivery the care. You need community involvement to understand the need is there, that there is a problem. Yet, you have to have someone who understands the cultural beliefs of those communities to pull the whole thing together. It is a very complicated problem.

Often in this country, we try to approach it as we do in Third World countries, and America is not Third World. Rural communities are not Third World. Therefore, we cannot approach them as Third World countries.

Senator SHELBY. If the Senator from Minnesota would yield——

Senator DURENBERGER. Yes.

Senator SHELBY. We are not Third World, but at times, because the areas are so under-served in some areas like Black Belt of Alabama, often we wonder, don't we, if——

Dr. HULLETT. We look that way, but the mentality is not the same.

Senator SHELBY. That is right, and the statistics look that way, don't they, Doctor?

Dr. **Hullett**. The statistics look the same, but the mentality is different.

Senator **Shelby**. Yes, the mentality is different. Thank you.

Thank you, Senator.

Senator **Durenberger**. Thank you, Mr. Chairman.

Senator **Burdick**. Senator Pressler.

STATEMENT OF SENATOR LARRY PRESSLER

Senator **Pressler**. Mr. Chairman, I have a written statement for the record.

In the Midwest, the drought has reduced the fiscal year stability of rural hospitals, nursing homes, and health care services. In South Dakota, 41 percent of the individuals in nursing homes are private pay patients. This percentage will decrease in the drought areas. A reduction of private pay patients could translate into less income for nursing homes. Hospitals will experience cash flow problems because farmers and ranchers can not pay their hospital bills on time.

Mr. Chairman, in my opening statement, I state that in South Dakota, the number of physicians has doubled since 1972 from 542 to 1,096. Even with this increase, there is a severe maldistribution of physicians in my State. Over one-half of these physicians practice in four urban hospitals located in the Sioux Falls and Rapid City areas.

Fifty-two rural hospitals averaging 35 beds in other areas of the State have a difficult time recruiting physicians. In fact, hospitals in my State have attempted to recruit physicians from overseas.

South Dakota has one of the highest concentrations of physician assistants in the Nation practicing in sparsely populated counties. These physician assistants play an important role in providing health care services to many rural areas that cannot recruit physicians.

South Dakota is also experiencing a severe shortage of nurses. Twenty-five of our fifty-eight hospitals feel the effect of a severe shortage of nurses.

Rural hospitals across our Nation are hit hard by these manpower shortages. I am pleased that the Senate Special Committee on Aging is examining manpower utilization in rural health care facilities.

Mr. Chairman, I would like to submit this statement for the record.

Senator **Burdick**. Without objection, it will be received.

[The prepared statement of Senator Pressler follows:]

STATEMENT OF SENATOR LARRY PRESSLER
BEFORE THE
SENATE SPECIAL COMMITTEE ON AGING

HEARING ON RURAL HEALTH CARE
JULY 11, 1988

MR. CHAIRMAN: I commend you for convening this very important hearing to examine rural health care issues. American citizens across our nation strongly believe that access to health care is a right and not a privilege. The rural elderly are losing the right to receive care in their local communities. Rural health care personnel shortages, and even the widely publicized drought, are reducing access to health care and the stability of the rural health care delivery system.

Six hundred of the nation's 2,700 rural hospitals "are at-risk of closure." Since 1980, 161 rural community hospitals have shut their doors. The closing of rural hospitals will have a devastating impact on the elderly who rely most heavily on these facilities. This would be especially true for South Dakota with 14 percent of its population over the age of 65.

The rural health care delivery system can no longer stand the strain of a weakened rural economy. In South Dakota, the tragic impact of the drought has further weakened the stability of the local economy and reduced the ability of farmers and ranchers to pay for health care services.

Over 580 individuals attended a recent public listening forum I held in the town of Eureka, to express their concerns about the drought. Many of these individuals were worried about how the drought would affect the financing of nursing home care. In that area, there will be fewer private pay patients to pay for nursing home care.

Although hospital and nursing home care are generally available in rural areas as in urban areas, the rural health care facilities are at a disadvantage in recruiting physicians and registered nurses.

It is more difficult for rural areas to recruit and retain new physicians because of lower reimbursement rates, professional isolation, inadequate health care resources, and an insufficient population base to maintain a private practice.

According to the South Dakota Hospital Association, South Dakota has the fourth lowest physician to population ratios of the fifty states. Over three-fourths of the physicians are practicing in towns of 10,000 or more.

Since 1972, the number of physicians in South Dakota has doubled from 542 to 1,096. Even with this increase, there is a severe maldistribution of physicians in my state. Over one-half of these physicians practice in four urban hospitals located in the Sioux Falls and Rapid City areas. Fifty-two rural hospitals, averaging 35 beds, in other areas of the state, have a difficult time recruiting physicians. Recently, the Ipswich South Dakota Community Hospital closed temporarily because it could not recruit a physician.

South Dakota has one of the highest concentrations of physician assistants in the nation practicing in sparsely populated counties. Physician assistants play an important role in providing health care services to many rural areas that cannot recruit physicians. The American Hospital Association (AHA) found that in 1984, 40 percent of the 5,914 surveyed physicians assistants were practicing in communities with fewer than 50,000 residents; 19 percent were in towns with fewer than 10,000 persons.

Historically, the nursing shortage has been more damaging to rural hospitals because of the difficulty of attracting nurses to rural areas. According to the American Hospital Association, in 12 primarily rural states, the number of registered nurses per 100,000 residents was below the national ration of 629 per 100,000 in 1984.

South Dakota is experiencing a severe shortage of nurses. According to a South Dakota Hospital Association survey, 51 of 58 hospitals are experiencing a nurse shortage. Even though South Dakota has 7,803 registered nurses in 1988 compared to 6,180 in 1982, South Dakota hospitals, nursing homes, community health nursing, home health agencies and educational institutions reported a shortage of 226 registered nurse and 56 licensed practical nurses.

Rural hospitals cannot compete with urban hospitals in providing higher wages and better fringe benefit packages. Older and married nurses may not have the flexibility to relocate to isolated rural areas. Some nurses may be unwilling to take on the heavy workloads and time demands that exist in many rural hospitals.

Mr. Chairman, too many rural hospitals have closed down completely or reduced their services because of a personnel manpower shortage. We must respond positively to the challenge of maintaining the availability of health care services for our rural elderly.

Senator **Burdick**. Senator Heinz.

STATEMENT OF SENATOR JOHN HEINZ

Senator **Heinz**. Mr. Chairman, thank you very much.

First, I would like to commend Dr. Hullett-Robertson on her award as Rural Health Practitioner of the Year. Of course, as Senator Shelby has mentioned, we are proud, Doctor, that you did attend the Medical College of Pennsylvania. It is a proud institution and, let me tell you, it started out as the Women's Medical College, and I was privileged to be the commencement speaker some years ago. I now have an honorary doctoral degree.

They have a tradition there of bringing back the 50-year graduates. Now, people didn't go right into medical college at age 21. It took a little bit of earning power. So, the average age of those 50-year graduates starts at about 75 and works well up from there.

You have never seen a stronger, more vibrant group of women, and I can see that Dr. Hullett-Robertson is cut from exactly the same cloth. In about 50 years when she goes back, she is going to be exactly the same as those alumnae groups.

Quite seriously, I want to commend you, Dr. Hullett-Robertson, and all the members of the National Health Service Corps who do work in the under-served areas of our country. Some are in rural areas. Some are in inner cities which I am sure you saw some of in the city of Philadelphia.

I do ask, Mr. Chairman, that my opening statement be a part of the record.

Senator **Burdick**. Without objection, it will be received.

[The prepared statement of Senator Heinz follows:]

Opening Statement
The Rural Health Care Challenge: Part 2: Rural Health Care Personnel

Mr. Chairman --

Assuring that an adequate number of health care personnel are available to meet the needs of America's rural communities has long been a concern of Congress and this Committee. Some 25 years ago the Congress began enacting a number of programs to get health care workers into those areas that would otherwise not have enough basic health services. While these programs have met with a fair amount of success, we still find today that the smallest rural communities -- those with less than 2,500 people -- only have an average of 30 physicians for every 100,000 people, compared to the U.S. national average of 163 physicians to 100,000 people. On this the 25th anniversary of Federal health manpower programs, the timing of this hearing couldn't be better to review these programs and where we are headed in meeting the health needs of rural Americans.

Compounding the traditional difficulties rural areas have faced in attracting health care practitioners, new problems are developing which place rural areas between a rock and a hard place. There has been an alarming increase in the number of Americans who are either uninsured or under-insured. This dramatic increase in the medically uninsured has made it more difficult for rural health care practitioners in independent practice to make a living.

In a Senate Finance Committee hearing in Wilkes-Barre Pennsyvlania, which I chaired, I heard one example of this problem from Joan McNaney. Mrs. McNaney's husband works on his father's farm in Bucks County Pennsylvania. Several years ago, their 12 year old son needed emergency brain surgery. The only insurance the McNaney's could afford at the time was grossly inadequate and left them responsible for over $10,000 in hospital bills and $7,000 more for physician services which they have been trying to pay off at $200 a month. This is a farming family whose income is dependent on the success of the season's crop. Because their monthly income is so unpredictable, the McNaney's have sometimes found it impossible to meet their monthly payment. This means that both the hospital and the surgeon may not get paid some months.

Adding to the burden of the uninsured, Federally supported programs designed to provide subsidized care to people in rural areas are operating with inadequate funding, threatening their ability to attract and keep enough practitioners. According to Dr. LeFleur who testified at that same hearing on behalf of the Community and Migrant Health Centers in Pennsylvania, the decrease in grant money for these clinics makes it difficult to maintain enough staff to serve the increasing number people in those communities dependent on their services as their only source of health care.

Other Federal programs designed to bring needed health care workers to shortage areas, such as the National Health Service Corps, have been gradually dismantled in the past several years. I am greatly concerned that elimination of sources of health care personnel like NHSC will leave previously underserved areas at risk once again if many of those serving in the Corps' leave their assigned area after fulfilling their commitment. The discouraging prospects for financial viability after leaving the Corps payrolls can be expected to make these practitioners wary of remaining in the most needy areas.

Although we have had considerable success in addressing the need for health care practitioners in rural areas, that success does not mean the problem is resolved. If we are not going to permit a backslide then we must continue to vigorously persue both public and private approaches. Considering the rock and hard place rural health care practitioners are finding themselves between, what more or different should be done to soften the pinch and make rural practice more attractive? I look forward to hearing today's testimony on various initiatives to attract and retain health care personnel in rural areas and the challenges that remain in ensuring that all Americans have access to basic health care services.

Senator HEINZ. I have just really one line of inquiry for Dr. Hullett-Robertson. You, in answer to Senator Durenberger, indicated that the main barriers, in addition to education and economics was familiarity with the health care providers. What I sensed you were saying is that in a small town in a rural area, people are not at ease with strangers. Am I reading between the lines correctly?

Dr. HULLETT. You are always an outsider. I have been in my area ten years, and I am still an outsider, but I have worked very hard to become a part of the community, and I think I have become a part of the community by working diligently in all aspects of community life, understanding the culture, ideas, beliefs, and thoughts of the community, being flexible.

Often, as health care people, we come in being straight technicians and wanting to deliver the care as we were in training and not taking into consideration the area's beliefs which may not always be congruent with what we think. We must, as health care providers, understand those.

Once you do that, then we are able to get more people involved in becoming a part of the health care delivery system, that is, coming to see health care deliveries not just because they are ill but to become a part of what we are trying to do now in health prevention and promotion.

Senator HEINZ. Of course, you wouldn't be where you are without the National Health Service Corps. As I understand it, the National Health Service Corps makes it possible for the clinic in Eutaw to exist. Isn't that basically right?

Dr. HULLETT. That is true, yes.

Senator HEINZ. To what extent does the National Health Service Corps sensitize people such as yourself—and, clearly, you are very good at it whether they sensitize you or not—to the need to respect and get to understand local values and customs and practices so that the health care provider is not some kind of distant outsider whom you only go to after you have tried everything else?

Dr. HULLETT. I really wasn't sensitized by the National Health Service Corps. Even though I was born and reared in Birmingham, Alabama, both my parents are from rural communities, and I had that experience of early visiting grandparents and learning somewhat about small town communities.

I also taught school for a year before working in a research center in New York at Columbia Presbyterian where, again, I was sensitized to the needs and concerns of a small community.

Senator HEINZ. But the National Health Service Corps doesn't give any——

Dr. HULLETT. It does. It does, and it uses people like me to help do that, someone who has had the experience, who has had good experiences and bad experiences, to work with young people to let them know what they are going into. Often, it is a culture shock when you get someone who has lived in Philadelphia or New York and never lived in a small town before and has to go to a small town and live.

So, they do attempt to prepare you.

Senator HEINZ. Doctor, just to summarize for the record, you made two really vital points, first, that the National Health Service Corps does provide a cadre of good providers such as yourself who are sensitive and able to deliver the kind of health care that is very needed in those rural communities and, secondly, that clinics or centers like the one that you are at would not exist without the National Health Service Corps. Therefore, our continued support for that and our expansion of that is vital.

Dr. HULLETT. Yes, it is.

Senator HEINZ. Thank you very much.

Senator BURDICK. Thank you.

Senator Durenberger, do you have any more questions?

Senator DURENBERGER. No, Mr. Chairman.

Senator BURDICK. All right, Dr. Hullett. Thank you very much.

Dr. HULLETT. Thank you for the privilege.

Senator BURDICK. Our next witness will be Mr. James May, Executive Director of a system of health clinics in northeastern Missouri. He has been very successful in utilizing the provisions of the Rural Health Clinic Act as a tool to attract physicians and other health care personnel to medically under-served rural areas.

Welcome to the committee, Mr. May.

Mr. MAY. Thank you.

STATEMENT OF JAMES L. MAY, EXECUTIVE DIRECTOR, NORTHWEST HEALTH SERVICES, MOUND CITY, MO

Mr. MAY. Mr. Chairman, I am located in northwestern Missouri so close to Iowa and Nebraska that we sometimes vote in their elections. [Laughter.]

I am not here to speak on the effects of the current economic crisis on access to primary care nor the fact that the drought that we are currently experiencing is going to make it even more difficult for us to survive. I am here to discuss—and I have a prepared statement that has been submitted for the record—the ongoing problem that has existed for several years in the shortage of physicians in rural areas.

Second, I will discuss the poor Medicare and third party reimbursement rate experienced in almost all rural areas today which is compounding the problem of access to care for the rural elderly, the poor, and anybody else who cannot travel or who lives a distance far enough away where they have to depend on a local health care system.

I heard considerable spoken this morning and in the testimony that I read about the shortage of rural manpower. I am only here to speak to the shortage of physician manpower in rural areas.

I think it is important to understand why we have the shortage that we have now. Senator Grassley mentioned earlier that Iowa is just replacing the physicians that they lose. They are not gaining any new physicians.

It is also important to know how many of those physicians are going to rural areas as opposed to non-rural areas. The percentage is disproportionate to non-rural areas.

That shift began about 30 years ago as medicine began to change in response to the technological age and the changes in medical practice, I think. Physicians were no longer family practitioners or general practitioners. Any physician was no longer willing to practice in a solo independent mode. It was not economically feasible for them to do so. They were deprived of peer support and all the other advantages offered in a group practice.

The non-rural physician forces tended to reorganize themselves into group practices or some other type of an organized practice of medicine so that, as a group, they could share call, share expenses, and expand their horizons to include some specialty services.

Rural physicians didn't do that. The rural practice of medicine, for the most part, in 1988 is the same as it was in 1958. They are solo independent practices in rural areas. A solo independent practice is not a competitive practice in today's recruitment marketplace.

Compounding that is the low Medicare reimbursement rate, and the Medicare reimbursement rate drives most other third party reimbursement rates. Blue Cross, Blue Shield, and most insurance companies that are major carriers in rural areas or any area follow Medicare's need in establishing the area's allowable charge for services.

I think it is important that the very lack of organized services in rural areas that caused the current physician shortage and our inability to attract physicians also has contributed immensely to the rural reimbursement inequity that providers experience. Physicians are not reimbursed on the same mechanism for Medicare or anybody else that hospitals are.

You have heard much testimony from hospitals. Their rates are set. Our rates are set by ourselves. Although I have not seen a lot written about it or heard a lot about it in that we blame Medicare for the low reimbursement rate, the fact is the physicians in rural areas low reimbursement rate is their own problem. It is our problem.

Since Medicare came out, the formula for reimbursement of rural provider physicians is based on their customary charge and the area prevailing rate. The area prevailing rate is nothing more than an aggregate of the customary charge.

So, if the practitioners in rural areas did not pay attention to administrative and management practice issues as their urban or non-rural counterpart who joined a group practice did, then, for whatever reasons—and they were probably very altruistic and home based and those kinds of things—they didn't raise their fees. So, as the practice of medicine shifted in non-rural areas and stayed the same in rural areas as an independent practice, fees did not go up. The physicians did not raise their fees.

If you do not raise your fees, your customary charge is going to stay the same and so is the area prevailing rate. That gap has expanded since 1965 or so to the point that it is nearly impossible now for our organization in northwestern Missouri—we have seven clinics—to provide reasonable primary care services to Medicare patients.

The fact is that we get paid about 40 or 50 percent less than it costs us to provide comprehensive primary care services to Medicare patients.

To that end, whether it is partly our fault or Medicare's fault, it doesn't matter, but the Medicare reimbursement rate is so low that it is rendering rural elderly second class status in the health care system. It is very difficult for me or anybody else or for a young family practitioner or general practitioner to decide to establish a practice in a rural area today.

First, they are going to be solo mostly, independent, and all the kinds of personal, professional, and family motivations why they are becoming physicians are not usually there in rural areas. There is a tremendous Norman Rockwell picture of a physician practicing in a rural area. The families depend on him and all those kinds of things.

The fact is that the families depend on him 14 hours a day, 7 days a week, 365 days a year, and there is very little time off. Combine that with the fact that they get 40 percent less income, and it isn't an issue of deep pocketing docs. It is an issue of whether or not we are going to have services in rural areas at all in the future.

The lack of organized services or reorganization of medical practices in rural areas has tended to leave the force of physicians who are practicing in rural areas in 1988 about the same as it was in 1968.

For instance, my clinics are in Atchinson and Holt Counties, Missouri, extreme northwestern Missouri. There are nine physicians practicing in the two-county area. Eight of those have been there 23 years. We have had one new physician in 23 years. He happened to be a local person whose family had long-term ties there.

Seven of the nine physicians that we had three years ago practicing in the two areas are at or past retirement age, and all of the seven have indicated to the community that they have imminent intentions of retiring. They have practiced there 30 to 42 years and had tried for several years to recruit a replacement to have somebody take over their practice—not buy their practice but take over their practice, just come and assume a practice. They were not successful.

We went there three years ago and reorganized the system, purchased seven of the nine practices, formed a group practice, and we have been successful in recruiting physicians. We have addressed and resolved the problems associated negatively with the rural practice of medicine in that it is an independent solo practice.

The other problem that was very difficult to address is that our Medicare reimbursement rate—incidentally, we have 50 percent of our business which is geriatric, Medicare. It ranges from 40 to 55 percent, but on the average, 50 percent of our total caseload is Medicare. In addition, 5 percent is Medicaid, and there are a lot of folks who can't afford to pay because of the economic situation in the area, but those things will probably change.

The Medicare reimbursement rate is not going to change. If it weren't for the fact that we have a Public Health Service grant, a 330 community health center grant to help get it started, we would not have been able to establish this system that we have, attract the physicians, and then address the other economic issues.

In looking at the problems of Medicare reimbursement, we did a fair amount of research and found that a little known enabling legislation, Public Law 95-210, was available for rural practitioners or rural clinics that wanted to become certified under P.L. 95-210 who are practicing in a health manpower shortage area and have a mid-level practitioner who could qualify for cost based reimbursement from Medicare and Medicaid.

One of our counties was a health manpower shortage area, and we have one family nurse practitioner. We became certified. We went through the process, and it is a very lengthy process, but so is everything else, I suppose. We got certified under P.L. 95-210 for two of my locations, two clinics.

A third clinic in Holt County I cannot get certified because I don't have enough family nurse practitioners to go around, although I have been successful in recruiting a board certified family practitioner for that clinic who is 32 years old and one of the first to come to the area for years although I can't be certified as a rural health clinic.

The other county is not designated as a health manpower shortage area and cannot be because they have five physicians. It doesn't meet the test. Four of those five physicians are at or post retirement age and have all said they are going to retire.

So, we have an imminent disaster on our hands of recruitment, but I can't get rural health clinic status until we are in a crisis situation.

What P.L. 95-210, the Rural Health Clinic Act, has done for us is enable us in those two locations—and they are our busiest locations—to recover our costs of providing services to Medicare patients. It is not a windfall. We are not getting rich. As as matter of fact, at the current rate, we are not getting paid for the volume of services as we are providing as they are 35 miles down the road in St. Joseph, Missouri where a limited office visit returns $21.40. The same thing is $12.60 in our clinic.

We have board certified family practitioners, magna cum laude, the same situation as 35 miles down. I buy my supplies from the same location. I compete for the same staff. We have no cost differential, but, nonetheless, I get paid half as much.

That is our problem. That is the problem of the physicians practicing in northwestern Missouri. We created the problem.

They are no longer going to practice, so they don't have to worry about it. They are, as I speak here, my friends, and they may not like my saying that, but it is the truth.

It is those who are left who are going to have to suffer. Enabling legislation like the Rural Health Clinics Act can resolve that.

I don't expect to have a Medicare overhaul of the rural reimbursement system. I think that is not going to happen. It may happen a little bit but not enough to where we are going to recover our costs.

I do think it is possible, however, to, with very minor modifications of the Rural Health Clinics Act, make it available for rural areas, not just health manpower shortage areas, but rural areas that meet the test. It would also require modification not only of the rural health shortage status but of the requirement to have a mid-level practitioner.

Just for anybody who wants to challenge me, I am not an opponent of the mid-level practitioner. I am a proponent of it. The fact is that they are very hard to get, and I have one, and I have clinics that could receive a lot of benefit on behalf of the Medicare patient if they could be certified even in a health manpower shortage area.

So, if those two requirements were relaxed, many other areas would qualify under cost based reimbursement. The one thing that

I would recommend if those things are relaxed is that there also be a proviso in order to be certified if you are not HMSA and you do not have family nurse practitioners is that you must demonstrate that you have reorganized the current system, that you have at least three practitioners who have gone together to become certified and have addressed the other issues that have created the shortage in manpower today. I think it would be very valuable use of existing legislation.

Thank you.

[The prepared statement of Mr. May follows:]

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THE CRISIS IN RURAL PRIMARY CARE:
THE POTENTIAL OF THE "RURAL HEALTH CLINICS ACT"

July 11, 1988

James L. May
Executive Director
Northwest Health Services, Inc.
Mound City, Missouri 64470

Member of Board and Community Operated Practices Constituency Director
National Rural Health Association, Kansas City, Missouri

Member and Rural Health Task Force
National Association of Community Health Centers, Washington, D.C.

Mr. Chairman, I am James May, Executive Director of Northwest Health Services. Northwest Health Services is a not-for-profit community based clinic established to plan and develop a practice environment capable of recruiting and retaining primary care practitioners and subsequently provide a comprehensive health care services system for Holt and Atchison counties in northwest Missouri. I am appreciative of the opportunity to address this committee as I am deeply concerned for the future of primary health care services in rural areas of the United States.

The problem has reached crisis proportions in many areas and requires immediate attention if we are to salvage and rebuild our rural primary health care system in most rural regions of our country. Since rural areas are home for a preponderance of the elderly and the elderly require the majority of our health care resources in this country, it is particulary important that we safeguard the perpetuation of a primary care system close to their home.

It is the strength and the stability of the primary health care system on which the patient and the total health care system depend in rural areas. That is, it is the physician that the patient depends on for health care. And, it is the physician the rural hospital depends on for its patient admissions and directing of care. Therefore, if the supply of physicians falls below that which is required to provide primary care services the rural health care system begins to fail. Consequently, those patients living in a rural area who must depend on their local health care system suffer the most. Those most severely affected are the elderly and the poor.

The supply of physicians has reached a critical shortage in many rural areas and the remaining supply is eroding at an accelerating pace. Either we find a way to transport patients to urban areas for health care in the future or we address and solve the problems that have created these shortages in rural areas, now. It will be much more cost effective to solve this problem and promote the stabilization of the rural system than to rely on the urban centers to provide the health care for the rural populations, especially the elderly.

If the factors contributing to this problem are fully understood, the solution is clear. And, it can easily be shown to be cost effective. Why does the shortage exist? Clearly over the last 25 years there has been a steady decline in the resupply of physicians in rural areas. This decline in resupply was, and is, due to the changing practice environment required of young physicians who comprise the resupply. Solo independent practices simply were and are not conducive to the professional and personal goals of the young physicians. In the late 60's the non-rural physicians recognized this trend and began to form private group practices and various other provider organizations which presented the "modern" physician with an attractive practice environment in which to practice medicine. Unfortunately, rural physicians did not "reorganize" as their non-rural colleagues did. Therefore, the rural practice of medicine remains independent and solo. Very few physicians have been willing to establish their practices in rural areas since this transformation began 30 years ago. that stagnation has created today's crisis.

Not only has this trend created a crisis in manpower, it has also contributed to today's very poor rural medicare reimbursement rate. This extremely poor and inequitable medicare reimbursement rate for rural medical care is directly a result of the evolutionary process that resulted in a shortage of rural practitioners. Currently, the medicare reimbursement is much less in rural areas than in non-rural areas for the same service. For instance, Medicare reimburses $12.60 for an office visit performed in Mound City, but $21.40 in St. Joseph, 35 miles away. Yet, the qualifications of our providers are the same and our costs are virtually the same for providing the same service. Therefore, the rural provider, theoretically, can allocate only one-half the time and resources to that Medicare patient's visit than the physician in an urban area can. Or, he/she simply has to work longer hours, see more patients, and, earn less.

In the experience of Northwest Health Services it actually costs about 50% more to provide services to Medicare patients than we can collect for these services. It therefore becomes economically impossible to provide a comprehensive outcome assessed system of care for our geriatric patients. This obviously impacts negatively on the quality of care for the Medicare patient in rural areas. Rural elderly patients are rendered second class status under the current Medicare reimbursement system in most rural areas. Given this situation, most primary care physicians are further discouraged from practicing in rural areas and select non-rural practice environments - the shortage crisis worsens and the rural inequity gap broadens.

This sub-standard reimbursement rate for rural practitioners is not Medicare's fault. It was the rural practitioners who created the problem not Medicare. To understand this, one must understand the method and formulas established by Medicare to determine physician Part B allowable charges. Very simplistically, a physician's allowable charge is his or her customary charge in relation to the area physician's prevailing charge. So, each physician establishes his or her customary charge which then combined with all the other customary charges in that area becomes the prevailing charge. Unfortunately, rural practitioners did not keep up with the non-rural "organized" counterpart as it related to attending to practice management issues dealing with fee schedules, billing sophistication, participation in Medicare, etc. They chose, for the most part, to ignore these issues. Most did not keep their fees current with their non-rural colleagues and chose not to participate in the Medicare program. Further more, because very few young physicians, who might insist on a more current fee structure, were establishing their practices in the rural areas, the area prevailing rate did not keep up with the non-rural prevailing rate.

Regardless of the cause, now that many of those physicians practicing in rural areas have retired or died and many more are of retirement age, the inequitable Medicare reimbursement rate becomes a major barrier for recruitment of replacement physicians even if the other problems associated with rural practice were solved.

Assuming the reimbursement inequities were resolved, the barriers would still exist which have created the shortage of rural practitioners in the first place. That is, very few young practitioners are willing to establish their practice in the existing practice environment in rural areas. Most practice opportuntieis in rural areas continue to be solo, independent practices. If we are to solve the rural physician shortage problem we are going to have to stimulate the re-organization of the practice environments in rural areas. Independent solo practices are not attractive to young physicians. Group practices or organized systems of care are competing and winning the new recruits.

If rural practice opportunities are going to be competitive, they must be a part of an organized system of care. These organized practice environments are competitive for a number of reasons depending on the individual physician's practice goals. It may be that they are attractive to a physician simply because of the financial advantages. It may be that they are attractive to the young physician because of the peer support that they offer. It may be that they are attractive to the young physician because of the sharing of after-hours call responsibilities. It may be they are attractive to the young physician because they offer an opportunity to practice in a system of care emphasizing quality. It may be that they are attractive to the young physician because they offer opportunities in academic or research agendas in addition to their practice of medicine. Or, they may be attractive to the young physician because they do not have to attend to administrative and practice management issues. There are many reasons why the organized practices of medicine offer far more attractive practice environments than do rural solo independent practices. Regardless of the reason, it is evident even to the most casual observer that rural medicine must be re-organized if it is going to be attractive to the young physician and thereby reduce the current shortage.

I have focused my testimony to this point on the cause and effect of the rural primary care crisis in general in order to illustrate that problems of access to care for and to the rural elderly is symptomatic of the problem. To attempt to solve the symptom rather than the problem would be futile. However, if the problem is solved, the symptom will fade.

I am here today because we at Northwest Health Services have found a solution to the problem that, with some modification, could be replicated in other rural areas. Northwest Health Services has purchased six of nine solo independent practices in a two-county area, formed a group practice environment and established a comprehensive primary care system embracing the concept of managed care and outcome assessment principles. We are successfully recruiting physicians. All the problems associated with solo independent practices were addressed and resolved in our group organization.

Northwest Health Services was originally funded by the U.S. Public Health Service as a Section 330 Community Health Center for Holt County. Then, as we became successful, our operation was expanded through a joint venture with our two-county community hospital to purchase practices of retiring physicians in Atchison County also. Originally, our two-county area had nine physicians, seven of which were retirement or post-retirement age. Only one of those nine physicians had practiced in the area less than 23 years. That means that we had only one physician establish a new practice in a two-county area in 25 years.

We had solved the problem of creation of an attractive practice environment, but not the inequitable Medicare reimbursement problem. Our practices average over 40% Medicare patients with two of our busier locations having an excess of 50% Medicare patient load. Therefore, the low Medicare reimbursement rate was particularly problematic. We were not recovering our costs of providing services to Medicare patients. If it had not been for the Public Health Service grant, we would not have been able to operate at all.

However, the rural economic crisis hit our operation very hard as it had most other rural areas. The Public Health Service support was quickly utilized to cover our patients who could not afford services. The number of patients in our area whose incomes fell below the national poverty guidelines and, therefore, could not afford to pay for services rose at a meteoric rate in 1986 and 1987. We experienced an 1860% increase in our demand for uncompensated care in 1986 over 1985 and that figure rose another 30% in 1987 over 1986. Therefore, we were forced to accelerate our research and investigation of a method for increasing our medicare reimbursement rate to a level that would cover our costs. Our research and investigation of the alternatives resulted in review of several options. One of which is a little-known law enacted in 1978 called Public Law 95-210 or the Rural Health Clinics Act.

The Rural Health Clinics Act allows a clinic in a rural area and a health manpower shortage area, who have the services of a mid-level practitioner, to be reimbursed for its costs of providing medical services to Medicare and Medicaid patients. There is currently a cap at $46 per visit. Since $46 per visit was considerably more than we were averaging under our existing Medicare reimbursement rate, we opted to pursue certification as a Rural Health Clinic in late 1987.

Only two of our clinics would qualify because only Holt County met the criteria of a health manpower shortage area and we only had one family nurse practitioner. Those two clinics were certified in April 1988. The certification process and the organization/administrative requirements should not be minimized by the lack of attention given here. However, it was completed and resulted in a marked increase in our reimbursement rate from Medicare and Medicaid. Those two clinics have experienced a combined net increase of nearly $100,000 per year which has enabled them to recover their cost of providing services to our Medicare patients. We no longer have to use our Public Health Service funds to subsidize care to our Medicare patients.

Unfortunately, only two of our clinics qualify for certification although they all are experiencing the same problems. The clinic in Holt County that cannot be certified does not have a nurse practitioner or physician's assistant, although we do have a recently-recruited residency-trained family practitioner to staff that clinic. The clinics in Atchison County cannot be certified because the county is not designated as a health manpower shortage area, although four of the five physicians are at or post-retirement age and have all declared their immediate intention of retiring.

However, for those areas qualifying, the cost-based reimbursement afforded through certification as a Rural Health Clinic can enable providers to provide quality medical care to medicare patients. It also eliminates the financial barrier to practicing in a rural area. Generally, most clinics who are certified have also addressed the other problems associated with rural practice and have created an acceptable practice environment. Other than a Medicare rural reimbursement overhaul, which is highly improbable, the Rural Health Clinics Act offers the only possibility for recovering reasonable costs of providing good medical care for our rural elderly patients.

With limited amendments the Rural Health Clinics Act could provide an excellent vehicle for promoting more rural "reorganized" practice environments capable of recruiting and retaining physicians and mid-level practitioners and the establishment of systems of care. This is a solution that addresses the problem and relieves the symptom as well.

The technical amendments required would be elimination of the HMSA requirement and the mid-level practitioner requirement. If these requirements were waived, I would recommend the addition of a requirement of reorganized practice environment. I think at least three practices in contiguous areas would be required to apply assuring a system of care and the auditing of that system. I don't believe that the intent of the law would be compromised since the intent was to extend Medicare/Medicaid reimbursement for mid-level practitioners where physicians' services were insufficient. It seems to be the spirit of the legislation to ensure patient care to medicare/medicaid patients not necessarily to promote the requirement of a mid-level practitioner. In our case, we have both physicians and mid-levels, but not enough mid-levels to go around to certify all of our clinics. Therefore, clinics staffed by physicians become ineligible for participation.

Secondly, the health manpower shortage area designation is a requirement that forces an area to wait until its remaining physicians quit practicing entirely before qualifying for participation. That is a self-defeating requirement. Why not allow a rural area to participate by virtue of being a rural area before a critical shortage exists. It would be much easier to salvage and build a system before it reaches the health manpower shortage status than after. There seems to be no reason for the criteria to exist other than my presumption that it was originally included as a limiting criteria to soften the independent mid-level practitioner issue. Therefore, as with the mid-level requirement, I do not see that the intent of the legislation is compromised by eliminating the health manpower shortage area prerequisite.

In summary, access to primary care services for the rural elderly is seriously threatened by forces totally out of their control. The rural primary care system has been deteriorating for over 25 years. That situation is rapidly reaching crisis status due to the approaching retirement age of a disporportionate percentage of the rural physician force. The current practice environment is largely solo independent entities which are not competitive in the recruitment marketplace. The reimbursement rate for services in the rural setting is much lower than in the non-rural setting for Medicare and other third-party insurance carriers which renders rural practice even more unattractive. Combined, these circumstances if not corrected, will leave rural areas with a critical shortage of physicians forcing rural residents to seek primary care in urban areas. This will increase the cost of health care tremendously and create a particular burden on the elderly and the poor. This trend can be stopped and the rural health care system stabilized and revitalized. Stimulus and incentives must be created to promote systems of care to take the place of the fragmented solo independent practices. The rural reimbursement rate for third party patients must be equal to non-rural reimbursement rates eliminating the disincentives for rural practices. The Rural Health Clinics Act could be the vehicle for providing such a stimulus.

Senator **Burdick**. Thank you.

If you had to list the major reasons from most important to the least why it is difficult to attract primary care physicians and other needed allied health professionals to rural areas, what would they be? Why is it less attractive?

Mr. **May**. It is less attractive and it is difficult to recruit physicians for two basic reasons. Most of the practices are solo independent practices that they are going to replace, and they are not attractive. They don't offer the advantages that an organized group practice offers.

Rural practice is not aesthetically unattractive. Small towns are not unattractive to live in, to raise a family in.

They are, in fact, attractive if you can solve the problem and create a reorganized approach so that a person getting right out of family practice can go to a location and be assured that they have a reasonable after hours call schedule, they have other physicians who share a common interest with them both professionally and personally, and that they can be fairly compensated for their efforts.

I think those are the only barriers to rural practice, but they are very major barriers.

Senator **Burdick**. I would think the last one would be the major major barrier.

Mr. **May**. Reimbursement?

Senator **Burdick**. Yes.

Mr. **May**. I don't agree with that.

Senator **Burdick**. You don't?

Mr. **May**. No. I think reimbursement is a problem. I think there are a number of physicians who are willing to practice in rural areas regardless of the reimbursement. The fact is, most young docs don't have any idea about economics anyway. So, I don't find that to be a major problem.

I think when you get out there, as the previous witness said, when you are out there, you find you cannot practice medicine in the manner in which you were trained simply because you don't get enough reimbursement to cover your costs. To that degree, I agree wholeheartedly.

The reimbursement problem is a major problem after you get there and you find out that you cannot provide preventive services. Preventive services are not covered in the urban areas either. I don't want to get off on a tangent, but where you are getting 50 percent to 100 percent more reimbursement for a Medicare patient in a non-rural area, you can afford to attend to the other issues of the practice of medicine that are not cost reimbursed.

In our particular area, we are pretty limited.

Senator **Burdick**. Thank you.

Senator Pressler.

Senator **Pressler**. Just as a footnote to that question, if I may——

Senator **Burdick**. You may add more than a footnote.

Senator **Pressler**. I get more than a footnote?

Senator **Burdick**. Yes.

Senator **Pressler**. As a footnote, how much does the liability insurance of health care professionals vary in rural areas and urban areas. Do you consider this a major problem?

Mr. **May**. It varies from—we probably experience a low for a family practitioner who is doing OB of $15,000 or $15,500 to a friend of mine in an organization that I established several years ago who is at $30,000, and that is three hours away.

I have no idea why. There is no difference in the status of the people they are serving, but there is——

Senator **Pressler**. Do you mean that professionals in rural areas have to pay more for their insurance?

Mr. **May**. No. Generally, it is less, but if you consider $15,000 for malpractice to be less, it is. But the point is that across the rural spectrum, it is not always less. A friend of mine in central Missouri is paying $32,000 for insurance.

Senator **Pressler**. If a physician practices in an urban area, does he pay more insurance for his liability?

Mr. **May**. I don't know the answer. I presume they do.

Senator **Pressler**. That would be very interesting to know. Maybe physicians in urban areas have a group policy?

I wonder if we could get this information for the record. The question is, do rural health care practitioners, doctors, nurses—and I suppose nurses, if they don't practice under a doctor, need liability insurance.

Mr. **May**. They do.

Senator **Pressler**. What is the difference in the amounts paid by physicians? Are there different rates? Can we get that information? Would you have a source to get that information for the committee?

Mr. **May**. Sure.

Senator **Pressler**. Great. Thank you.

Senator **Burdick**. Senator Durenberger.

Senator **Durenberger**. Mr. Chairman, I am going to take a minute at this point to thank you for this hearing and to compliment the staff. As you know, I have spent a lot of time in this area, and I had an opportunity over the weekend to read this paper presented by the staff on this issue, and it is as good if not better than anything I have ever come across in terms of a succinct statement of the problem. We don't often enough compliment our staff for these sorts of things.

I think we are all well aware. Jim May has done a terrific job this morning in outlining the problem that we face in rural communities, and many factors contribute to this financial distress, including the increased burdens of uncompensated care which we are going to hear about this morning. A lot of that is due to distressed economies in some areas, the decline in in-patient hospitalization due to changing clinical practices, and new third party reimbursement systems, and then low payments to rural hospitals which Jim talked about under the Medicare program which is as much a fault of history as it is of the Medicare system, but that doesn't mean we can't do something and probably shouldn't be doing something about it.

Small community hospitals face further demands of deteriorating physical plants and difficulty in recruiting and retaining staff which we address today, but they are the focal point for all health care delivery in rural communities. The one place that everybody trusts is the local hospital. It is the place where we are now trying to do mental health and do a lot of other things, because somehow people just trust this place called a hospital.

So, I think for most of us from rural States, part of the answer to solving the personnel problem is doing something about the hospital problem in rural America.

I have been working in the Finance Committee to increase payments to rural hospitals. While we have increased payments to rural hospitals more than to urban hospitals, we still have a long way to go, and I would like to explore that with these witnesses today.

There is another way we can help rural America by helping its hospitals, and that is to adapt the hospital and the medical center to the realities of today's health practice. There is regionalization going on, whether we like it or not. It is driven by high technology and, in some cases, by the fact that physicians need to practice in groups, as Jim has indicated to us.

So, you can't expect a group in every little town. You are lucky to have a physician in every little town, a general practitioner or a visit from specialists or something like this.

But the closing of hospitals is ridiculous. Closing the medical facilities in communities is ridiculous, because it is the place in every community to which people can reliably look to get this broad spectrum that we in America call our health care.

So, that is why I came up last year and you all agreed to pass the authorization for the rural health transition grants, a $50,000 a year grant for up to two years which would enable financially stressed rural hospitals to develop and implement strategies for responsive change in these communities, and Congress authorized the grants. There is only $15 million a year to cover the whole country. My colleague here on my right, Senator Burdick, made sure that we got the $15 million in the Appropriations Committee, and now we have a little problem over on the House side, because they have only appropriated $3 million to implement this program.

So, I would like to take this occasion to encourage everybody on this committee and others to take a little time and lobby Chairman Natcher and Congressmen Obey, Smith, and Weber—Vin Weber happens to be from my State, Neal Smith is from Iowa, and David Obey is from Wisconsin—in order to do this little bit of $15 million program which I think would go a long way to resolving the problems. It would be the beginning of solving some of the problems of the physician and nursing crises as well.

Jim, having complimented on what I think is the reality of your statement, let me also suggest I agree with you that the nature of practice is going to change and it ought to change, and the solo practitioner is going. There isn't much we can or should do about that, I don't think. Yet, we still have the pressure from the communities.

Everybody wants to have their hospital like they have the high school and the basketball team and/or football team, whatever the case may be. But I think what you mean by group practice is that you might have a solo practitioner in town but he is tied in in some way or other with a larger group so that there is a community of professional interest.

Mr. MAY. That is right.

Senator DURENBERGER. And when you responded to Senator Burdick's question about is it just reimbursement or something else, and you said yes, reimbursement is important but there is something else, is it accurate to say that the something else is the professional rewards from this community of professional interest as well, that these newer physicians, as they—and we have a situation in Minnesota where—and I agree with your statement—we have young physicians who won't come out to rural Minnesota for $85,000 or $95,000 a year. They will stay in the Twin Cities for $35,000.

Mr. MAY. That is right.

Senator DURENBERGER. So, your point is an accurate one. Do you agree with the fact then that if we can encourage, in one way or another, whatever it takes, the sensitive grouping in the best sense of the word of physicians that this is an important way to bring the young physician or new physician out to a rural area?

Mr. MAY. It is critical. I don't think monetary—you say $85,000. That is right. We do not compete on high dollar first-year salaries.

If I may, when I say a group practice, I mean exactly what you are saying. We have practices, in some cases, which are one physician in a community. They don't all have to be in the same building. You can provide the professional reward of a group practice in rural communities as long as they will work together.

We happen to be tied totally. It is not just a private practice association. They are employees with the same contracts and all that. We own the practices.

We also have a joint venture with our only local community hospital, and they help underwrite some of our activity. We brought all our resources to bear on that one issue.

An organized practice does not necessarily mean that a community of 2,000 or 3,000 can't have a physician. What it means is if they are going to continue to have their physicians, they are going to need to look at joining with another community.

There are as many buzz words as there are ideas about it, but it is a group practice. So, they can market their venture as a group practice, and that is the only way they can solve their problems and why people don't want to go. If they do that, I think they will recruit physicians.

That is why I think that the rural health clinics application, with some modification, would be an excellent stimulus to promote that. It would tie in the low reimbursement with the need to reorganize.

Senator DURENBERGER. Now, the related question—and I am going to ask Kevin this also—is all the other professions. It is nice to have the docs grouped up and all that sort of thing, but the reality is that in emergencies and a lot of other situations, you want professional care as close to the problem in time as you possibly can.

Mr. MAY. Sure.

Senator DURENBERGER. Another large part of this professional problem in rural areas is the non-physician professionals and how they can be attracted. I looked at what the staff said about that. Again, they said it is a lot more than money. There are a lot of things that hospitals and other community resources are not doing today that might help.

A lot of that is working conditions. A lot of it is—and this is the question I am going to ask you—the relationship between the non-physician professionals and the physicians. How do you resolve that? The average nurse in America makes 17 percent of what the average doctor makes. Yet, in so many cases, according to this report, and in many of the cases we know in rural America, the nurse is doing almost exactly the same thing.

How do you view that kind of relationship and what we ought to do there?

Mr. MAY. In relation to my testimony, I know that I have at least two—I am not going to be able to recruit any family practitioners or any mid-level practitioner if I don't have a hospital. There are places that do not have hospitals that have physicians and nurse practitioners, but in our particular case, all those that I have recruited would not stay if the rural hospital weren't there.

That is why it has been very important for the rural hospital and ourselves to work closely.

By the same token, yes, mid-levels or allied health professionals are in scarce supply. As long as you have a reimbursement inequity, they are going to stay in short supply.

I can't afford to pay the kinds of salaries that I need to if I am not going to get reimbursed for it. It isn't a matter of whether you want to or you don't want to or you agree philosophically or not. If there are no dollars, I can't pay it.

It would help our system tremendously if I could attract more mid-level practitioners. We don't have enough physical therapists at our local hospital.

Senator DURENBERGER. But here is where we get to the reimbursement issue.

Mr. MAY. Right.

Senator DURENBERGER. I mean, we may not be there on physicians, but we are there when we get to all the rest of the medical support system that we need in those communities. Just because the physicians or the small hospitals in the past have not been—I mean, their charges are so close to their costs that the country is getting a bargain. If we don't break that link somehow, what it means is that the hospital, the community, or the group cannot afford to attract and to hang onto the other kinds of ancillary or mid-level personnel.

Mr. MAY. Perhaps it is a chicken and egg theory. In the case of physicians, it is not my most critical issue, but it is very close to it. I have to have both of those things.

In the case of hospitals, when I do get a system established, if I am not reimbursed at the same rate—or I don't care what urban areas make—just enough to cover our cost which still may not be as much, but in our case, I don't see why it should be worth any less for a rural practitioner or, more importantly, for a rural patient to receive less medical benefits than someone who just happens not to live in a rural area.

Our whole system cannot survive unless we can get reasonable reimbursement for our costs.

Senator DURENBERGER. Thank you.

Mr. Chairman, thank you.

Senator BURDICK. We have a vote on. We will stand in recess for 10 minutes.

[Recess taken.]

The CHAIRMAN. The committee will come to order.

Our next witness, I am happy to say, is Pat Nessland. Pat is the Director of Nurses at the Frances Mahon Deaconess Hospital in Glasgow, Montana. She has had many years of experience in rural nursing and taking care of the people out there, and we are glad to have her here so she can advise us on what the prospects are of alleviating any nursing shortage in our State or other States like it.

So, welcome to Washington, Pat. We appreciate your coming here to give us this testimony, and we are looking forward to hearing from you.

STATEMENT OF PAT NESSLAND, R.N., DIRECTOR OF NURSING, FRANCES MAHON DEACONESS HOSPITAL, GLASGOW, MT

Ms. NESSLAND. Thank you. I am really pleased to be here.

An issue I would like to mainly discuss is the nursing shortage. First of all, Glasgow, Montana is located in the northeast part of Montana, and it is kind of midway between Regina, Saskatchewan; Bismarck, North Dakota; Billings; and Great Falls, Montana. We are about 250 miles away from a larger health care facility.

Senator Melcher, if you were visiting in Glasgow, Montana and suddenly developed chest pain which is the first symptom of a heart attack, you would expect us to take good care of you and meet your medical needs. At this time, we have a well qualified intensive care unit and a staff that can take care of you.

However, with the nursing shortage, I am really concerned that we may not always be able to do this. Probably the first service that would go in our small community hospital would be our intensive care unit. We have had some times in the past two years that we have been awfully close to eliminating this service, even on a temporary basis, and I would really hate to see this be eliminated completely.

This service is really vital to our rural health area. We have had a stop-gap measure of using registry nurses to alleviate our problems. We have been fortunate to get good people and to continue our service.

Critical care nurses are in high demand, and it has not always been easy for me to even recruit temporary nurses to Glasgow, Montana.

While the registry nurses have given our regular nurses time off for vacation and allowed us some time for orientation of new employees, it does really add to our budget, because they are a lot more costly than our regular staff. You must realize that we are recruiting on a national level. Yet, we are penalized by the rural differentials. We are paid much less for each DRG diagnosis than urban hospitals.

We know that we must keep our current R.N. staff satisfied to keep them in hospital nursing. We know some of the traditional reasons that nurses are not in nursing and some of the problems with hospital nursing with the scheduling, medical staff, and administrative relationships. We work hard in all of these areas.

Many times, the R.N.'s who are working staff end up working extra hours. This includes me. I have worked a lot of extra hours. In particular, it seems like the 11 to 7 shifts when people call in sick. That is when it is, and there is nobody else to work it.

We also extend our professional staff by using a lot of nursing aides.

Some of the things that we are looking at in our hospital to help our problem is using recruitment firms to help us locate a person to work for us on a full-time basis, not just a temporary basis, but we have had little success in that.

We bonus the new R.N.'s $1,500. We give them half when they arrive and half in six months. We assist with their location expenses. We use the registry nurses.

We try to locate a job for a spouse which is one of the main concerns. We have had a few nurses who have been interested in coming, but their spouse has had no job, and this is difficult in our low economic area.

We have tried job sharing with other hospitals. This is something that worked in the past, but now, the other hospitals are having an equally difficult time recruiting nurses as we are.

We are trying as much as we can to be flexible on our hours. Sometimes, they do have to work extra hours, but, in the meantime, I bend over backwards to give them all their requests off that they want.

We are trying to be competitive with salaries. We are going to try something new now. We say we are going to grow 'em at home. We are grooming some of our nurses aides to go away to school, offering them monetary assistance, in return for a two-year commitment at Frances Mahon.

We are also thinking of starting our own registry to offer services to Montana, Wyoming, and Idaho at this time. We are just early in the stages of this planning. This hopefully would give us a better in for getting registry nurses for ourselves.

We are also right now recruiting a Master's prepared nurse who could be a professor at a nearby community college and be a satellite in Glasgow, Montana, putting the nursing students in Glasgow, doing their studies via telecom, videos, and then doing their clinical aspect in Glasgow. Hopefully, they will like what they see and stay after they have completed their education.

I think also we need more methods for people like me who have a diploma and want to get a bachelor's and, eventually, a master's degree, but I am not willing to give up my family life and my career to go on campus for an extended period of time. I would really like to see more of this independent study way of furthering education, and I think that would be beneficial to some of our staff nurses, too, who are A.D. programs or diploma program graduates.

I don't have much more to say. I really thank you for being here, and I would like to respond to any questions you might have.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Nessland follows:]

Testimony on the Nursing Shortage
Before the Special Committee on Aging
United States Senate
July 11, 1988

by

Patricia L. Nessland, RN
Director of Nursing
Frances Mahon Deaconess Hospital
Glasgow, Montana

My name is Pat Nessland. It is an honor to be here today. I am an RN and Director of Nurses at Frances Mahon Deaconess Hospital in Glasgow, Montana. I have been in nursing for 22 years, 17 of them at FMDH. Two and one half years ago, I was appointed Director of Nursing. I have a diploma in nursing, and this June I completed a 2 year independent study program at the University of Minnesota in Nursing and Patient Care Administration. I have plans to pursue a bachelors degree if I can find an independent study program that will meet my needs. I belong to MONE (Montana Organization of Nurse Executives) and last fall was appointed to an advisory committee at Montana State University, on the nursing shortage.

FMDH is a JCAH accredited hospital with 48 acute care beds, 6 skilled nursing beds, and 24 chemical dependency beds. We have a 4 bed ICU and have OB, ER, medical and surgical services. We also have a dedicated fixed wing air ambulance service and hospital based ground ambulance.

I have had a serious concern whether we can continue to offer all of the above services in the future. Our RNs have worked many 12 hour shifts in addition to their routine 8 hour days. I have worked months of 11-7 shifts: some of the shifts have been scheduled, but many of them came in addition to a 10 hour day in the office. When someone calls in sick and there were absolutely no other RNs to fill in the 11-7 shift, I covered the shifts.

We supplement our RN staff with nursing assistants and rely a great deal on their eyes and ears to extend our nursing capabilities. Our RN staff consists of 23 RNs who are part time and full time, 8 LPNs and 30 nursing assistants.

We have had recruiting firms searching for RNs for flight nursing since last fall and for 2 years for the positions of 3-11 and 11-7 supervisor. There has been no success in any of these areas. Some of the problems we face are in attracting an RN to Glasgow, Montana which is a rural remote location, insufficient jobs for spouses, and to some extent salary. We have found some RNs interested in relocating, but have not been able to find a job for the spouse. Registry nurses speak very highly of our staff and hospital's capabilities.

We have tried job sharing with other facilities nearby: a workable temporary solution in the past, but now other hospitals have just as great a problem staffing their hospitals as we do. We have used many temporary nurses over the past 2 1/2 years. This is only a stop gap solution which is costly and does not provide continuity in care. We pay the nurse $3.00 an hour more than our staff nurses, $160.00 per week to their agency, housing and travel expenses round trip.

Some of the traditional reasons that nurses do not go into or stay in nursing are conflicts with medical staff, hours, and lack of administrative involvement. We work hard on all of these areas: I personally "bend over backwards" on scheduling, we have a supportive medical staff with good relationships and administration is constantly improving salaries, benefits, and working conditions, plus give personal attention to the nursing staff.

Due to DRGs, we do not get reimbursed enough to cover higher costs of temporary nurses. We are losing 30-60 thousand dollars a month on DRGs. Medicare deductibles increased 1/2 million dollars from $500,000.00 to $1,000,000.00 this fiscal year. Committee members you must realize we are recruiting on a national basis yet you are penalizing use through rural differentials. Paying us much less than you are paying the urban hospitals. We are very concerned about the survivability of our rural health system under this current rationing of health programs.

Some of the solutions we are considering and/or presently doing are:

1. Job sharing. We did recently receive relief for a long weekend, from a flight RN from a larger hospital.

2. Three nursing assistants are going to school to become RNs we are providing monetary assistance in return for a 2 year pay back of them working a FMDH.

3. Bonus to RNs, $1500.00, 1/2 on hire, and 1/2 in 6 months.

4. Assist with relocation expenses.

5. Locating jobs for spouse.

6. Recruiting a masters-prepared RN so we could have an extension Professor from Community Colleges in Glasgow. The students would do their clinical here and courses would be via satellite and/or videos.

7. Opening a temporary nursing service out of Glasgow, Montana for Montana/Wyoming, Idaho. This is being considered through a co-op effort or through FMDH independently.

8. Flexible staffing.

9. Competitive salaries.

10. Incentives for academic achievement. ie: Academic programs off campus to the "grass roots" - "grow them at home" without leaving our campus. We have 3 people now doing this, through home study for X-ray.

While we are rural, we are not unique. We need access to independent study for people like me, for example, who wish to pursue a bachelors and eventually a masters. Going on campus with a family and career is nearly impossible. Studying via independent study, satellite or telecom would enable many to further their education, and still maintain full employment. This could benefit many in health care. Congress needs to redirect funds towards off campus education which would allow working people to improve their status, while at the same time maintain employment.

In conclusion, we are working hard at Frances Mahon Deaconess Hospital to provide methods of recruitment and retention of RNs. We want to continue to be proud of the care we deliver. The nursing shortage is frightening and very real in Northeastern Montana.

The Chairman. Pat, what are you paying a nurse now who is a licensed, experienced nurse?

Ms. Nessland. We start a new graduate at $10 an hour now starting July 1. Our salaries just went up to $10 an hour for a new graduate.

The Chairman. And then what after a year or so?

Ms. Nessland. Then we have a scale that is based on experience. I would say probably our head nurses are making around $13 or $14 an hour.

The Chairman. So, when you try to recruit somebody and you are talking to someone who has had ten years of experience, it is going to be somewhere between $10 and $13 an hour?

Ms. Nessland. Yes, it is based on experience.

The Chairman. And roughly 40 hours a week.

Ms. Nessland. Yes.

The Chairman. You are in competition, you mentioned, with hospitals no matter where they are, metropolitan areas too, and you mentioned that Medicare deductibles increased from $500,000 to $1 million this fiscal year. What do you mean by that? What is that $500,000 to $1 million this fiscal year?

Ms. Nessland. I am not sure. I can't answer that.

The Chairman. I thought I was getting that out of your testimony.

Ms. Nessland. You did. My administrator helped me with that part.

The Chairman. Well, the DRG's—you are losing $30,000 to $60,000 a month on DRG's. Is that also what the administrator of the hospital says?

Ms. Nessland. Yes.

The Chairman. How do you think that translates into your hiring nurses?

Ms. Nessland. Well, that money that we could use for more innovative things is lost because we aren't recouping those losses.

The Chairman. And that is what you are in competition with, the hospital that is getting paid more for a specific service, DRG, for Medicare patients. You get less in Glasgow.

Ms. Nessland. Yes.

The Chairman. So, you have less to help out with paying the nurses.

Ms. Nessland. Yes.

The Chairman. So, it is part of the same trap, isn't it?

Ms. Nessland. Yes.

The Chairman. I think it is outrageous. I think it is absolutely outrageous that we allow this to continue where a Medicare patient getting exactly the same service in a rural area is going to be able to bill Medicare for a percentage of what would be the payment out of Medicare for exactly the same thing if it were done in a metropolitan hospital.

Ms. Nessland. Exactly the same thing. Exactly the same care.

The Chairman. And if we want to further penalize rural America, we can just continue down the path we are on where we say just because the patient lives in rural America, we are not going to put out the same amount of money as if the patient lived in metropolitan Washington, Minneapolis, or any of the other metropolitan areas.

I mention Minneapolis-St. Paul sort of as a prelude to what my good friend to my left here, Senator Durenberger, might wish to bring up in the form of questions or comments.

Senator Durenberger?

Senator **DURENBERGER**. Mr. Chairman, thank you.

I certainly associate myself with your remarks about the inequities in reimbursement. I hope we will have an opportunity to ask some questions about that later on.

Pat, I wonder if I might ask you a question about nurses and part of the delivery system in rural areas. As I indicated earlier, I looked with interest at the report that our staff put together in which they talk about some of the realities facing nurses today.

The mean average hourly compensation rose only 4 percent between 1985 and 1987, all the way up to $12.70 an hour. The average maximum salary is only $7,000 higher than the average starting salary, and, as I indicated earlier, salaries, on the average, are only 17 percent of physicians.

Then, there is a decline in enrollment in undergraduate programs. There are enhanced economic opportunities elsewhere and probably will continue to be. There is a lack of professional respect accorded nurses in some hospital settings.

Then, they reach the conclusion that there is a good cause for caution in formulating a Federal response. In other words, don't just rush in with money.

This has always been one of my problems, because, obviously, the nurses' association and other professional organizations say if we can just train more nurses and all that sort of thing, it would be great, but the reality is, as pointed out here, I think, that "most hospitals have not responded to the shortage with the tools at their disposal. These include increased wages, improved working conditions, increased career mobility, and, simply, increased respect."

I have the impression that in many rural communities, the predominant number of nursing professionals are women and that, in many cases, they are in that community because there is a spouse who is employed in that community who runs a small business in that community, has a farm or a ranch in that community. So, they put up with lower wages, less than ideal working conditions, less than ideal career mobility, and lack of respect.

What is your observation?

Ms. **NESSLAND**. I agree with that. I think that trend is changing a little bit now with more depressed farm areas and the nursing wives—or the wives, generally, because it is predominantly female—it is more important to them now to have a bigger salary to support things that are not working that were working in the past. They are not just a second income that maybe is insignificant now. They are needing that money to help maintain their families.

Senator **DURENBERGER**. As you may be able to tell, if there is anybody from the Administration here, the chairman and I are trying to impress them with the fact that if they just approach this problem of urban-rural differential on the basis of history in the payment system, they are going to be able to find rationale for saying there is really little justification for what all of us have been arguing, a national rate which distinguished urban from rural only on the basis of demonstrable resource cost differential.

I think one of the opportunities we have in this hearing today is to demonstrate not only the fact that in a lot of communities like Glasgow and others, the DRG payment is less than charges. In many cases, it is probably less than cost or at least very close to cost.

The fact that they are that low makes it very difficult for that hospital in that community to deal with all of these other issues here for the mid-level or ancillary professionals. You cannot increase your wages unless you have a big company in town with a third party payor who doesn't care.

That is great, but if you are in a tough economic situation in a predominantly agricultural area, you have a whole lot of elderly people, and 65 to 70 percent of your hospital's business is Medicare or Medicaid, you can't increase wages. You can't improve working conditions. You can't improve career mobility. You can't get into nursing education programs because the closest college is umpteen miles away. You can't do much about the increased respect business if you haven't the financial resources to do it.

Does that sound to you like the kind of statement——

Ms. **Nessland**. It does. You know, in-patient census any more doesn't keep us going, because our in-patient census is definitely lower than it has been in the past, and it is not a money maker any more. We rely on out-patient services to help keep us afloat, and we are small. The money isn't big.

Senator **Durenberger**. Mr. Chairman, thank you.

The **Chairman**. Senator Burdick?

Senator **Burdick**. If you could single out one strategy that you think would be most effective in recruiting nurses in rural areas, what would it be?

Ms. **Nessland**. I think the best strategy in my mind is the education part of having a satellite for us, anyway, in Glasgow, Montana to where we could have some visibility in our rural area and attract people that way.

And it is not only our hospital that is considering it. It is some other smaller hospitals that are considering being satellites of a community college for nursing students.

Senator **Burdick**. And you think that would appeal to nurses?

Ms. **Nessland**. Yes, I do.

Senator **Burdick**. Thank you very much.

Ms. **Nessland**. Thank you.

The **Chairman**. Pat, there may be a lot of very significant things you will continue to do in your profession. How long have you been a nurse?

Ms. **Nessland**. I have been a nurse for 21 years. I have been in Glasgow for 19 years.

The **Chairman**. 21 years a nurse and 19 years in Glasgow. How long have you been in charge of nurses at Frances Mahon?

Ms. **Nessland**. I have been director for two and a half years.

Senator **Burdick**. Just a minute, are you from Glasgow?

Ms. **Nessland**. Yes.

Senator **Burdick**. I played football at Williston, North Dakota.

Ms. **Nessland**. All right.

Senator BURDICK. In the Glasgow game, I broke my arm. [Laughter.]

Senator DURENBERGER. That was just last year, too. Right? [More laughter.]

Senator BURDICK. That is true.

The CHAIRMAN. Where did they set the arm, Senator? In Williston or Glasgow?

Senator BURDICK. Williston.

The CHAIRMAN. Armed with that bit of history, I am sure you will go back to Glasgow a lot better informed than when you came here, Pat.

I wanted to say that you have a lot of important decisions to make every day, and because of that, people come to rely on you. I wanted to tell you that coming here to testify and telling us the way it is in Glasgow which is typical of most rural areas across the country, you may have done more for your profession than any other one single thing.

If we can make this hearing meaningful and make some sense out of this so there can be some better recognition of what is happening with the loss of nurses in rural areas—it is pretty much a loss of nurses everywhere, but the rural areas get the worst end of it—if we can make some sense out of this and move on to help improve that, you have really done a good day's work here.

Ms. NESSLAND. Thank you.

The CHAIRMAN. And you are a very real and very credible witness, and I appreciate that very much. Thank you, Pat.

Ms. NESSLAND. Thank you.

The CHAIRMAN. I would like to call now on Senator Burdick to introduce our next witness.

Senator BURDICK. I would like to call Dr. Kevin Fickenscher to the stand, please.

I would like to extend a special welcome to the doctor. Dr. Fickenscher is considered an expert on rural health issues, both in our home State of North Dakota and across the country. Furthermore, Dr. Fickenscher is a personal friend.

It is always a pleasure to see you in Washington. I appreciate you taking time from your busy schedule to share your expertise with us today. It is a pleasure to have you with us, Doctor.

Dr. FICKENSCHER. Thank you very much, Senator Burdick.

Senator DURENBERGER. Mr. Chairman, if I could bust in right here before he starts, I would say he isn't just a North Dakotan. As Quentin has said, he is known all over the country. Just to demonstrate how well known he is and how much respected Kevin is, he is even loved in Minnesota right next door and especially admired for his talent.

I just want to reinforce that in case anybody thinks that is just sort of patriotism on Quentin's part.

Senator BURDICK. Well, the good doctor votes in North Dakota. I know that.

STATEMENT OF KEVIN M. FICKENSCHER, M.D., DIRECTOR, CENTER FOR RURAL HEALTH SERVICES, POLICY AND RESEARCH, GRAND FORKS, ND

Dr. **Fickenscher.** Thank you very much, Senator Burdick, Senator Durenberger, Senator Melcher. It is a real pleasure to be here today.

I have provided you with written testimony, and what I intend to do is to focus on a couple of my written comments.

I have to tell you that as I start my testimony, I am a little bit nervous. This is the first time I have ever talked without my cowboy boots on, so it is kind of unusual for me.

One of the first things I would like to do is share with you some thoughts about what we mean by rural. I think one of the primary issues is that we tend to lump all rural areas into the same category. As you all know from your work on the Senate Rural Health Caucus, that doesn't quite work.

One of the areas I believe is quite critical on the definition issue is to look at the frontier areas. When we define frontier, we generally define them as those counties of less than six people per square mile.

Most of the frontier areas are west of the Mississippi River. There are actually two east of the Mississippi River. One is up in Maine. It is a forest. The other is a swamp in Florida.

However, as you look at frontier areas, primarily, they are in the Great Plains and western States. A good friend of mine defines frontier as the "middle of everywhere", and I think that is really quite true.

The reason frontier is important is that when we look at North Dakota and when we look at Montana and Minnesota, the number of frontier counties has actually increased. For North Dakota, we have seen a growth from 16 counties in 1970 to 30 counties in 1980. It is projected in 1990 that North Dakota will have around 40 counties out of 53 that are frontier. That is a significant change.

The reason I highlight these areas is that frontier areas often lack resources. As we look at our health care system, I think it is important to look at how we can sustain services in those areas.

There has been very little research on the area of "frontier". It is just beginning, but I think it is an important concern.

One example that I can give you is a study that was done in Colorado on emergency medical services. What that study showed is that for urban areas, it costs about $10 to $12 per capita for EMS. In traditional rural areas, it costs around $20 to $25; and, in the frontier areas, it is greater than $50 per capita. So, you can see that the actual per capita costs are a significant problem in frontier areas.

There are a number of issues that I think are really quite important when we look at the question of health manpower. I am going to highlight these issues for you. First I believe it is absolutely essential that we continue the support of primary care training and community-based medical education models.

During the 1960's, we encouraged the development of medical schools. North Dakota transformed from being a traditional medical school to being a community-based medical school. The University of Minnesota at Duluth expanded. Montana developed programs as part of the WAMI (Wyoming-Alaska-Montana-Idaho) effort. Those types of medical school programs, I think, are quite essential in training family physicians, and primary care physicians, for rural areas.

If we look at North Dakota, we are retaining about 42 percent of our graduates now which is really quite good. Of those graduates, before we had the community-based program, about 33 percent went into primary care. Now, it is around 43 or 44 percent. So, we have made a substantial impact on the types of individuals that we are actually training.

A second issue that I think is important as we look at the rural health care system—and something that you have all talked about already this morning—is the need to resolve the inequities in the reimbursement system, particularly for Medicare.

I adhere to the principle that we need to have equal pay for equal work, and I know Senator Durenberger has heard me say this many times, that we need to be able to pay physicians that provide the same service on the same type of patient for the same type of problem and provide them with the same reimbursement, especially when we look at the cost of those practices and realize that the cost of an urban and a rural practice are essentially the same.

The inequities that exist are not only documented in places like *Medical Economics* and some other studies, but, recently, the Congressional Budget Office showed that internists in rural areas are reimbursed at around 50 percent less than their urban colleagues for exactly the same types of service. Inherently, the Medicare system discriminates against rural physicians.

It seems to me that we need to have a policy on reimbursement that is in concert with our access policy. If we are trying to get physicians out to the rural areas, it doesn't do any good to penalize them by reimbursing them at 25 to 30 percent lower rates.

The reimbursement system has a clear impact on access to physician services. One of the things that has been clearly shown to affect medical student decisions is indebtedness levels. As you all know, medical students are increasingly indebted as they go into practice, and that is a factor.

Another issue that I think is important on this whole reimbursement and access question is the availability of manpower. There has been considerable discussion about the supply of physicians and the fact that we have too many physicians. I would not want to sit here and tell you that we don't have too many physicians.

We do, but they are in the wrong specialties. I can tell you right now that if you are a hematologist or a gastroenterologist that you are not very well prepared to go into practice in rural America. We need certain kinds of physicians. In fact, if we look at it, the number of family physicians and the number of general internists is actually insufficient.

A report that just came out last week from the Council on Graduate Medical Education stated very specifically that there is an under-supply of family physicians and general internists, something that those of us in rural America have known all along.

At The Center for Rural Health, we are involved in recruiting physicians all over the upper Midwest. We work in the three States that are represented here today. We are finding that it is harder to recruit family physicians now for rural areas than it was five years ago.

In part, the reason that it is harder is that family physicians are being recruited by pre-paid health systems. In addition, they are going into larger clinics. For example, the Fargo Clinic which is a large multi-specialty clinic in Fargo, North Dakota did not have a department of family medicine four years ago. It now has 20-some physicians as part of that department. They have discovered the need to have primary care physicians as part of their system.

I think the other issue that is really quite critical are the results of a study recently completed by David Kindig, M.D. a colleague at Wisconsin. The study showed that the growth in physician supply in rural areas has been substantially lower than the growth of physician supply in other parts of the country. As a matter of fact, it has only represented about 10 percent.

Senator Grassley in his opening comments talked about how there has been a net loss in family physicians for areas in Iowa. I would suspect that if we looked at the Iowa data a little closer, we would find that the loss is even more significant in that the family physicians that have been coming in to replace those that are leaving are locating in urban areas. They are not locating in rural areas.

So, the differential loss is actually that much greater than the statistics might otherwise point out.

Very quickly, I would like to talk about two other issues that I think are also important. One of them relates to nurse practitioners and P.A.'s, physicians' assistants.

These providers evolved out of the 1960's when we were trying to develop systems to deal with health manpower shortages, and although there has been a shift in recent years, a large percentage of these graduates still go into rural practices. We basically have two models. We have a free market system approach to education where we have programs and individuals enroll. Then, when they graduate, the NP's and PA's go wherever they can find jobs.

We also have another model which is not nearly so prevalent called the deployment model. The deployment model takes individuals from Glasgow, Montana into a training program, and then places them back into those sites for training and supports them. What happens is that those types of graduates tend to go back to those rural areas.

One of the things that I think is really important as we look at education systems is that we use the right type of system that is going to train providers for those rural areas. If we look at the graduates of the University of North Dakota nurse practitioner program which is a deployment model, it would show that 71 percent of the graduates go into rural practice. That compares to a national standard of around 25 percent.

You can see that there is a substantial difference in the relative impact of those kinds of training programs. Also, I should point out that 65 percent are in primary physician shortage areas, and 33 percent are in designated health manpower shortage areas.

We have also noticed a marked increase in enrollment. In fact, certain really severe areas with a shortage of physicians like the Indian Health Service are looking to that model as a way of dealing with their problems.

The second issue is an issue that I think is very important. It has been touched on today. As we look at rural health, I think it will probably become one of the primary health issues of the 1990's, and that is the shortage of nurses.

I have to tell you today that I am very concerned about what is happening in rural America. We haven't seen the shortage as it has occurred in some of our larger urban areas, but I believe that when that shortage finally does hit rural America, it is going to be much more difficult to deal with than it is in the urban areas for a couple of reasons.

One is that the type of graduate that we need in rural areas is a nurse generalist. As we look at most of our educational programs, they tend to train nurses who are coming out as specialists. They want to be nurses that work in the coronary care unit or in renal dialysis or whatever, and what we need in rural areas are general nurses.

Most of our educational programs don't emphasize rural nursing. I think Ms. Nessland pointed that out very well in her testimony.

A second issue I think is important is that, traditionally, rural areas have relied upon less-than-baccalaureate-trained registered nurses. As we see the shift towards baccalaureate nursing which, I have to tell you, I agree with and think that is a good move on the part of nursing, we need to also then emphasize within those baccalaureate programs a rural component.

And it is not going to be done just at the master's level. In fact, there has been some emphasis at trying to train master's level rural nurses. Well, master's level nurses aren't going to be the answer for rural America. We need baccalaureate level nurses.

Finally, you face the same issues in recruitment. Then, finally, as you pointed out, Senator Durenberger, the reimbursement rate is a major issue. You have rural hospitals that have 60 to 70 percent of their income coming from Medicare. The urban-rural wage differential is clearly discriminatory in this way, and it makes it very difficult for these rural hospitals to provide an adequate wage and to compete.

Competing for nurses is done on a state-wide or regional level. It is not done at the local community level.

My final comment is—and I really don't have time to get into it—but I also think that a lot of the issues that I have highlighted here for physicians, for nurse practitioners and P.A.'s also apply to physical therapists, mental health workers, et cetera.

I think one of the most exciting things that is happening in this area is a program in Alabama at the University of Alabama. They have developed a multi-competency technician program where they are actually training general technicians, and that is something that we really need in rural areas.

The interesting thing about the graduates is that a lot of the urban hospitals are recruiting those multi-competency technicians because they also could use them as well.

So, those comments are a summary of the types of issues that I think must be addressed for rural health manpower. If there are any questions, I would be more than willing to answer them.

[The prepared statement of Dr. Fickenscher follows:]

Perspectives on Health Manpower Issues Facing Rural America in the Coming Decade

Kevin Fickenscher, M.D.
Director, The Center for Rural Health
Past President, National Rural Health Association
University of North Dakota
Grand Forks, North Dakota

Statement Before

The U.S. Senate Select Committee on Aging
Washington, D.C.

July 11, 1988

Mr. Chairman and Members of the Select Committee on Aging:

Thank you for inviting me to share some thoughts with you on the important issues related to health manpower which must be considered if we are to effectively deliver health care in rural America in the coming decade. My name is Kevin Fickenscher. I am a board-certified, Assistant Professor of Family Medicine and Associate Professor of Community Medicine at the University of North Dakota. I serve as the Director of The Center for Rural Health Services, Policy and Research; the only university-based health sciences research and policy program in the country devoted exclusively to issues concerning rural health. In addition, I also am involved in education as the Co-Director of the Family Nurse Practitioner Program within the Department of Community Medicine and Rural Health at the University of North Dakota. These multiple roles have provided me with experiences in education and research which coupled with my experiences in working with rural communities represent the framework for my comments today.

Over the last decade I have worked extensively with rural hospitals, physician's offices, and communities in evaluating programs designed to sustain quality, local services in rural. I also recently completed my term as the Immediate Past President of the National Rural Health Association, a multi-disciplinary association of health professionals devoted to increasing the awareness of rural health as an important concern in America.

On behalf of rural providers throughout the nation, I want to express my sincere appreciation for this opportunity to share with the members of the Committee some of the issues affecting the availability of rural manpower. In discussing rural health issues I believe it is essential to consider our definitions of rural. Too often "rural" is lumped together as one large group which does not recognize the inherent diversity and complexity of the rural regions of the nation. We do not place all urban areas into a common category of "city". Although substantial work must be made to better characterize the rural areas of the nation, certain common definitions have evolved over the last two years.

First, the common definition used by the Department of Labor are those counties of 100,000 population or less referred to as Standard Metropolitan Statistical Areas (SMSAs). Another common definition used by the Bureau of the Census defines rural as any population of less than 2,500 people. All data and most research which has been accomplished on rural areas uses one of these two definitions. Two other subcategories of rural include: adjacent rural and frontier areas. These two definitions have yet to be clearly delineated. It would appear, however, that including the definitions in examining health services would more clearly define such considerations as access to health manpower.

Adjacent rural areas are those adjacent to SMSAs. The characteristics, resources, and needs of these communities appear to be quite different than the more traditionally defined rural community. Frontier areas are generally defined as those areas of 6 people per square mile or less. 1/ Research on the inherent differences of health care in frontier areas has only recently begun. As a result, it is difficult to quantify the characteristics of these areas at the present time. On an anecdotal level, however, it would appear that there are considerable differences in frontier areas from more traditional rural areas. One of the primary issues is the lack of available resources in virtually all categories for sustaining any level of service. This problem is particularly acute for rural health where it is generally accepted that rural people have the same rights to basic health services as their more urban counterparts. The sparsity of the population creates another problem with the cost of sustaining services. As an example, the cost of emergency medical services averages $10 - $12 per capita in urban areas; $20 - $25 in traditional areas; and, in excess of $50 per capita in frontier areas depending upon the population density.

Rural America possesses a number of common strengths and weaknesses that affect the type and level of health care services provided in rural communities. Weaknesses evident in rural America include: 1) a lack of sufficient critical mass to support selected programs and services; 2) a fluctuating economy dependent upon agriculture, forestry, extractive industries, or small manufacturing industries; 3) transportation difficulties due to the lack of public systems; 4) a general shortage of professionals despite excellent opportunities in rural communities; 5) lower-than-average income for the rural population as a whole; 6) skewed population demographics with a relatively higher percent of people age 65 and greater in communities experiencing a concomitant decline in the young, active working-age population; and, 7) fewer available resources to accomplish the delivery of services at comparable levels to urban areas.

Despite these difficulties, rural America has inherent strengths which make creativity and change more feasible at a time when our health care system needs these attributes. Specifically, rural communities possess an established interdependence and cohesiveness in attempts to resolve problems. These characteristics allow for greater mutuality in identifying barriers to sustaining services and programs related to health care. Rural people have greater access to local resources and are better able to facilitate communication between the six identified critical sectors of the community, including: the dominant economic force, education, commerce, health, religion, and government.

I highlight the relative strengths and weaknesses of rural areas as a way of demarcating the distinct differences from characteristics common to urban America. One of four Americans, one in three elderly, and over half of the nation's poor reside in rural America as defined by the Bureau of the Census. Although these groups do not represent a majority, they clearly represent a sizeable proportion of the population whose interests are often neglected and forgotten in policy deliberations and decisions.

Those of us from rural areas have come to expect indifference from the vast bureaucracy relative to the problems and concerns particular to rural America. It is of some comfort that in recent years our policy makers have come to not only appreciate -- but also advocate -- the specific concerns of rural America. The concern expressed by the U.S. Congress must, however, extend beyond the decline in the rural economy over the last five years and the drought of the last two months. We desperately need a national rural policy. Rural health is but one symptomatic element of the overall situation facing rural America.

An Overview of Medical Education and Recruitment/Retention Issues in Rural Areas. Through the initiatives developed during the 1970's to deal with the physician manpower shortage, a series of "new medical schools" were funded by the federal government. The purpose of the schools was to enhance the supply of physicians, particularly for underserved areas of the nation. By and large, these medical schools evolved with a primary care orientation. The primary care medical schools share some common characteristics. They include: 1) an early emphasis on primary care within the curriculum, 2) strong departments of family medicine are evident within the schools, 3) a portion of the teaching faculty are community-based, and 4) primary care receives strong support throughout the curriculum. As an example, the University of North Dakota School of Medicine is such a community-based, primary care-oriented medical school. Other examples include the University of New Mexico, the University of Minnesota at Duluth, Michigan State University and Wright State University. In addition, a large number of Area Health Education Centers (AHECs) were also funded for the purpose of expanding primary care education for rural areas.

The curriculum of the University of North Dakota serves as an example of the philosophical base for the new, community-based, primary care-oriented medical schools. Within the first two days of training students are introduced to primary care and rural health. The primary care emphasis cares through in the curriculum with problem-based learning modules which include primary care types of problems. Upon completion of the basic science education, students take a required primary care rotation in a rural community hospital situation. The students then complete the core clinical clerkships where a minimum of 8 weeks of family practice are required. Finally, the students return to the original rural community for a final 8 week education experience prior to entry into an internship or residency.

The results of the training program are impressive. The Center for Rural Health recently completed a comprehensive survey of graduates of the University. 2/ The purpose of the study was to assess the impact of having a four year, degree granting medical school compared to the two year basic science medical school at North Dakota from 1905 to 1972. The retention rate of graduates from the University of North Dakota program is about 42%, or double the number of retained graduates from the old basic science program. Also, the number of primary care graduates (i.e. family practice, general internal medicine, and pediatrics) increased from 33.5% for the period 1966-75 to 43.2% for the period 1976-85. In sum, primary care oriented medical schools can make a difference for rural areas.

Medicare Part B Reimbursement Policy. Before outlining the particular rural health issues emanating from Medicare Part B policy, I believe it is important for the Members of the Committee to understand that I adhere to a principle of "equal pay for equal work". The principle should serve as a guide in the development of effective policy related to rural health. At the present time, Medicare policy does not adhere to the principle.
A position of non-discrimination based on geography is consistent with other federal policies establishing uniform national payment rates. For example, rural areas of the nation pay the same federal income tax rates for equivalent income. The elderly receive the same social security payments regardless of geographic location. Postal workers receive the same pay despite residing in a range of communities from large metropolitan to frontier.

The same policies which guide the direction of other federal programs should be applied in health care as well. Moreover, such a policy would serve to address the egregious inequities in access and coverage to which rural Americans have been subjected under current Medicare physician or hospital payment methods. Under the current arrangement, rural residents pay a disproportionately greater share of their per capita income for health care services than do urban residents of similar socioeconomic status. The average annual expense per person for personal health care services in 1977 was $621 for residents of SMSAs and $534 for residents of non-SMSAs. Of those expenses, 32% were paid out-of-pocket by the non-SMSA families and 30%, for SMSA families. The major difference, however, was in the fact that non-SMSA families had only 82% of the mean family income of SMSA residents. As a result, non-SMSA residents paid 10% more of their out-of-pocket income for medical expenses than the SMSA residents. 3/

Geographic variation in the payment rate for physicians evolved from the historical pattern of charges submitted by physicians. The payment rate for both urban and rural areas was generally determined according to the prevailing charges. In rural areas where the prevailing charges were derived primarily from general practitioners, family physicians and other primary care providers, the charges were in fact lower relative to other specialties (e.g. cardiologists, radiologists, surgeons, etc.). As a result, the "prevailing charge" of the rural physician was inherently biased downward in comparison to urban fees. The geographic variation was finally institutionalized in 1975 with the adoption of the Medicare Economic Index (MEI) which was used as the basis for updating prevailing fees.

The Congressional Budget Office recently issued a report which noted that the Medicare reimbursement rate for an office visit to an urban physician averaged 50% more than the same service provided by a rural internist. 4/ Since the office visit constitutes the majority of the Medicare practice for rural physicians, the negative impact of the geographic differential is clearly evident. Not only is the policy negative for the rural physician but it also results in a greater out-of-pocket expense for the beneficiaries residing in rural areas.

The issue of Medicare reimbursement policy and its impact on rural areas can be considered from two vantage points. One relates to the impact of the policy on access to physician services and the second, the actual cost of practice in rural settings.

o **Access to Physician Services.** Although there are many factors affecting the inadequate supply of physicians in rural areas, I believe one major consideration is the lower Medicare rate. As an example, rural providers are particularly sensitive to Medicare reimbursement policies since they are involved in more care to the elderly than comparable practices in urban settings. 5/ Unfortunately, no good research is available which can be cited to support this particular contention.

Evidence is available, however, which indicates that the degree of medical student indebtedness influences practice location. 6/ It can be anticipated that the growing levels of medical student indebtedness resulting from escalating tuition costs and shrinking financial aid will result in a strong disincentive to enter a rural practice. Over the time period of 1975 to 1985 -- when the supposed huge physician surplus was evolving -- the ratio of physicians per 100,000 population in urban areas was higher than rural areas by 29% and 49%, respectively. During the same time period the rate of increase in physician supply was 46% for urban areas and, 25% for rural areas. 7/ Recent research reveals that counties with resident populations under 10,000 the physician-to-population growth rate in physician supply was only 9.4% over the same decade. This represents only one-third of the national physician supply growth rate over the same period. 8/ Finally, the Council on Graduate Medical Education released it's final report on June 22, 1988 stating that "significant uncertainties could change the assessment" of the physician oversupply. The report states unequivecally that rural and inner-city areas continue to have "inadequate numbers of physicians" while admitting that the problem is "not as severe as it has been in the recent past." The report also cites an undersupply of family physicians and general internists, the primary physician providers in most rural areas of the nation. 9/

- Cost of Practice. Considerable debate on the cost of practice issue is evident in the ongoing deliberations related to the impact of Medicare reimbursement policy on rural practice. The Physician Payment Review Commission (PPRC) preliminary findings indicate that the cost of rural practice is less than urban practice and, that deflating Medicare prevailing charges by the cost of practice index accounts for most of the existing geographic differential in Medicare prevailing screens.

  The conclusions reached by the PPRC contradict reports in Medical Economics and data supplies by the American Medical Association. AMA data indicate that median professional expenses for rural general practitioners and family practitioners are on average $10,000 higher than for the same specialties in urban settings. 10/ Medical Economics conducts regular surveys of physicians on a variety of areas. In a survey completed in 1982 the professional expenses of all physicians practicing in rural areas was $56,070 compared to $52,000 to $54,000 for physicians practicing in other locations. 11/ In 1985, professional expenses had grown to $69,220 for rural physicians compared to $60,000 for urban physicians and $69,220 for suburban physicians. Over the three year period the percent of gross income supporting overhead increased faster for rural practices than for physicians in the other two settings. 12/

Aside from the intricacies of the Medicare reimbursement system, there is another perspective which is too often overlooked -- that of the consumer. Medicare Part B participants all pay the same monthly premium rate, regardless of where they live -- urban or rural. Recent unpublished data reveals that higher per capita expenditures are directly related to higher population densities. Few exceptions were noted in the study. 13/ It would then appear that rural Part B participants are subsidizing the care of urban participants which is a perverse cross-subsidy given the relative higher degree of poverty in most rural areas compared to urban settings.

The Role of Nurse Practitioners and Physicians' Assistants in Rural Areas. Over the last twenty-five years much has been written about the role of the nurse practitioner and physicians' assistants in providing care in rural settings. In fact, the mid-level practitioners evolved as a profession in response to the physician manpower shortages evident in the 1960's. In 1971 the Department of Health and Human Services recommended extending the role of trained nurses to include primary care functions where the physician and nurse would share responsibility. The funding of nurse practitioner programs resulted in a marked expansion in the availability of these new providers in multiple different roles.

The major emphasis of both the physicians' assistants and nurse practitioners, however, have been in training primary care providers -- many of which practice in rural areas. A recent report by the Purdue University Department of Agricultural Economics outlined the current number of certified PAs/NPs, the subspecialty area of training and, the geographic distribution within a twelve (12) state area of a central region of the nation (i.e. North Dakota, South Dakota, Nebraska, Iowa, Missouri, Minnesota, Michigan, Illinois, Ohio, Wisconsin, Indiana and Kansas). According to the report, slightly less than 75% of each group currently serve in a "part-shortage" area with the remaining practitioners in "non-shortage" areas. 14/ 1987 data from the American Nurses Association reveals that although the largest percent of NPs now enter practice in urban settings (i.e. 47.3%), the rural areas continue to attract about one-quarter of the graduates.

It is estimated that within some practice settings, the PAs/NPs are capable of providing between 70 - 90% of the functions available from a physician 15/, often at a lower cost. Another consideration is whether or not PAs and NPs are accepted in rural practices by the consumers. Although data on patient satisfaction with such providers is not extensive, work that has been accomplished reveals that they are readily accepted. The most recent work by Oliver, et.al. concluded that the patients were "highly satisfied" with such services. 16/

In rural practices, we have seen an increasing appreciation and enthusiasm for mid-level practitioners. There are two basic types of programs available for training PAs and NPs. One approach is the "free market" model where individuals enroll in available programs throughout the nation. These programs have substantially increased the supply of PAs and NPs over the last decade. In addition, there are a much smaller number of "deployment" model programs. These programs train indigenous individuals from particular populations and, upon completion of the training, the new PA or NP is redeployed to their original setting. The difference in the programs is important since their relative impact on rural areas is substantially different.

The University of North Dakota has had a Family Nurse Practitioner Program since 1972 and is a deployment model training program. The graduates of the programs are eligible for certification as both Physicians' Assistants and as Nurse Practitioners. Since it's inception, the program has trained over 300 graduates. Of interest, is the increasing demand for the graduates and increasing class size over the last two years.

In part, we believe that the growth in interest in the Family Nurse Practitioner is the direct result of increasing difficulty in attracting Family Physicians to rural areas. As I mentioned previously, it is more difficult to recruit a primary care physician to a rural setting now than it was five years ago. As an example, the Aberdeen Office of the Indian Health Service recently indicated to The Center that they are exploring the use of more nurse practitioners and physicians' assistants in rural settings because of marked difficulty in recruiting physicians.

Results of surveys conducted by the UND program support the nation that these providers can make a substantial difference in supply of rural providers. Once again, it is important to note that the UND program is a deployment model program. The most recent survey reveals the following:

- 65% of the graduates are in family practice situations
- 71% are in rural practice settings of less than 30,000 population
- 65% are within the county of a primary care health manpower shortage area
- 33% are located in Health Manpower Shortage Areas (HMSA) designated by the Department of Health and Human Services

I do not want to suggest that the PA/NP is the panacea for providing practitioners for rural settings. The same problems encountered in recruiting physicians apply to these mid-level providers. The major difference is in the training programs. Most of the PA/NP programs are primary care oriented although a marked shift toward specialization has occurred for PA training programs in recent years. The training emphasis clearly results in practitioners desiring and appreciative of rural practice.

The Nursing Shortage and Rural Health. In the last year considerable debate has evolved on the issue of the nurse shortage affecting the nation. As late at 1983, the Institute of Medicine indicated that "no significant national shortage" of nurses existed. According to the federal projections released in 1987, the demand for baccalaureate-prepared registered nurses will exceed the supply by 390,000 within the next several years. By the year 2000, the gap is expected to exceed 1,000,000. 17/ The gap in nurse availability comes at a time when a decline in nurse enrollment is being experienced.

There has been a high degree of variability in the impact of the nurse shortage throughout the nation. The impact on rural America has been mixed to-date. In some areas such as rural Kansas and California, the shortage has been a significant problem. In North Dakota, the rural hospitals have yet to face a significant shortage. The shortage, however, appears to be a more significant problem in rural areas than in more urban areas for the following reasons:

- **responsibility level of rural nurse.** Nurses generally have a wider range of duties in rural facilities than in more urban settings. As a result, the nurse must be a generalist in order to function at an appropriate level. Also, a single vacancy because of the relative smaller size of the rural hospital or nursing home staff can result in greater compromise in the quality and range of services.

- **dependence upon less-than-baccalaureate trained nurses.** Rural facilities have relied upon non-baccalaureate trained registered nurses in the past. If the move toward a baccalaureate standard is not coupled with a "grandfather clause" for existing nurses and, if additional emphasis on rural nursing is not provided within our training institutions; greater difficulty in recruiting nurses may result.

- **difficulty in recruiting and retaining nurses.** Unlike the urban settings, the recruitment of nurses to rural areas will not be solved by dollars alone. As a result, a strong, community-level support of recruitment efforts will be needed. Once again, the issue of training nurses from rural areas is an important consideration.

- **rural hospital reimbursement rates.** In prior testimony you have heard about the inequities that exist in the reimbursement system for rural hospitals. In essence, the data provided to the committee supports the notion that rural hospitals are consistently underpaid relative to their urban counterparts for the same service. The inequity is particularly acute in the wage differential for hospital employees. Where a hospital is reliant upon the Medicare system for 60% of its total revenue (NOTE: a common situation), the ability to shift dollars into additional salaries for nurses is quite difficult. To effectively address the payment of nurses in rural settings, it is essential that the Health Care Finance Administration (HCFA) policies which discriminate against rural facilities be abandoned. Rural hospitals compete on a statewide or regional basis for nurses. The urban-rural wage differential, then, is a major impediment to effectively dealing with the problem over the longer term.

Several reasons appear to be precipitating the nurse shortage. First, only the most acutely ill patients are cared for in hospitals. Some researchers suggest that this has resulted in a higher rate of "burnout" among nurses.

Second, the peak earning power of the average clinical nurse is reached within 5 to 7 years starting with a salary of $20,340 and a maximum average of $27,700. Faced with that reality, many nurses seek different career paths either as part of or outside of health care.

Third, a shift in women to other rewarding career opportunities is occurring at a substantial rate. Women hold 97% of the nursing positions in the United States. This trend has important ramifications on the future of the profession.

Fourth, federal support of nursing education programs has declined dramatically over the last six years. Furthermore, with the move to a standardized registered nurse training at the baccalaureate level, less emphasis will be on general nursing if past trends continue. Most baccalaureate programs are located in urban areas, have a specialization influence and, do not promote rural nursing. As a result, the shortage -- when it finally hits rural America with full force -- may be more difficult to resolve.

Conclusions. In sum, the health manpower problems for rural America have not been solved. There continue to be shortages of family physicians and other primary care physicians which despite some predictions may be getting worse rather than better. In addition, we are now faced with the potential explosion of a nurse shortage which will no doubt be more difficult to resolve in rural areas than in urban settings.

Furthermore, our federal policies conflict with one another. As a nation we support programs designed to encourage physicians and other providers to move to rural area. On the other hand, we discourage these same providers by reimbursing them at substantially lower rates for the same service, provided in the same types of settings, for the same problems with the same resource requirements.

We must continue to recognize that answers for rural America do not lie in simply taking urban solutions and applying them to the country. The new Federal Office of Rural Health was an important step in that direction within the Health Resource and Service Administration (HRSA). The Office has facilitated greater appreciation of the unique characteristics of rural America and, the need for equally unique answers. The foresight of the U.S. Congress in pressing for such an Office and, in the Department responding to the need by creating such an Office are to be commended.

Finally, I look forward to returning to these hearings at some future date with news that we have solved the problems outlined in this paper. I hasten to add that it will take energy from all of us -- the Congress, the educational programs and those in the field -- to resolve the ongoing health manpower needs of rural America. Thank you.

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2/ The Center for Rural Health; *Retention and Recruitment of University of North Dakota Medical School Alumni: A Comprehensive Report*. University of North Dakota Internal Report; March, 1988.

3/ DeFriese, G. H., and Ricketts, T.C.; *Primary Health Care in Rural Areas: An Agenda for Research*; Foundation for Health Services Research; Washington, D.C.; December, 1987.

4/ Personal Communications with Charles Huntington of the American Academy of Physicians' Assistants.

5/ *Ibid*.

6/ Fruen, M.A., Hadley, J., and Korper, S.P.; "Effects of Financial Incentives on Physicians' Specialty and Location Decisions"; *Health Policy and Education*; 1(2); March, 1980; pp. 1-19.

7/ American Medical Association Council on Medical Service; *Access to and Quality of Rural Health Care: Report to the 1987 AMA House of Delegates*; Chicago, Illinois; June, 1987.

8/ Kindig, D.A. and Movassaghi, H.; "Trends in Physician Supply and Characteristics in Small Rural Counties of the United States: 1975 - 1985." National Rural Health Association; Kansas City, MO; July, 1987.

9/ American Medical Association. *Report of the Council on Graduate Medical Education*; Chicago, Illinois; June, 1988.

10/ American Medical Association. *Socioeconomic Characteristics of Medical Practice: 1986*. Chicago, Illinois; 1986.

11/ White, J.S.; "City versus Country Practice: Which Pays Off Best Today?"; *Medical Economics*; March 5, 1984. pp. 256.

12/ Paxton, H.T.; "Do Doctors Finally Have Expenses Where They Want Them?" *Medical Economics*; November 10, 1986. pp. 150.

13/ Personal Communications with Robert T. Van Hook, Executive Director, National Rural Health Association.

14/ "Mid-Level Health Professionals Filling Physician's Void in Rural Areas"; *FOCUS*, Vol. 5, No. I., The Center for Rural Health, University of North Dakota, Grand Forks, ND; July, 1988.

15/ *Ibid*.

16/ Oliver, D.R., *et.al.*, "Patients' Satisfaction with Physician Assistant Services." *Physician Assistant*; July, 1986; pp. 51 - 60.

17/ "DIRECTION: The National Nurse Shortage", *FOCUS*, Vol. 4., No. 2.; The Center for Rural Health, University of North Dakota, Grand Forks, ND; July, 1987.

The **Chairman**. Doctor, did you put a figure on what Medicare pays a physician for taking care of a Medicare beneficiary in a rural area that is less than if it were for a Medicare beneficiary in a metropolitan area? Did you put a figure on that?

Dr. **Fickenscher**. Yes. It ranges from 25 to 30 percent less except for six areas of the country, four States, and two sub-regions. North Dakota happens to be one of the four States where there is an equal payment for urban and rural, but the rest of the country, Montana included, does have a differential.

The **Chairman**. Why does North Dakota not have a differential?

Dr. **Fickenscher**. That is a real good question. I think it relates to the inherent politics of North Dakota and the fact that it is a very rural dominated State and that up until a decade ago, rural physicians were by far the greater number.

The **Chairman**. Now, if a physician is giving a flu shot—let's just use that as an example—to an elderly patient, are you saying that it would be less in a rural area than if he were giving a flu shot to an elderly patient under Medicare in a metropolitan area?

Dr. **Fickenscher**. Yes. I am saying that the service charge, the allowable charge that a physician makes is less for exactly the same service.

The **Chairman**. And it just follows on through. I am a veterinarian, and I can tell you as a veterinarian I did not move to a rural area in order to make less money practicing veterinary medicine.

Lawyers, when they move into a rural area, at least in my experience, don't go to a rural area to make less money. They generally move in there to make more money than they would some other place. That is my experience.

Why would physicians want to move into a rural area to make less money?

Dr. **Fickenscher**. Well, I think there are lots of reasons why individuals practice medicine. It might not be common, but a lot of physicians go into rural practice because they like to live there.

The **Chairman**. All right, how many?

Dr. **Fickenscher**. I would say that——

The **Chairman**. Percentage-wise.

Dr. **Fickenscher**. As a rural physician, if you don't like living there, the chances of your going to a rural area are really quite remote. That is one of the primary things that we look for when we are trying to identify physicians—individuals who have some desire to go practice in a rural area—because the likelihood of retaining a physician in a rural area if they come from a large urban area is relatively remote unless they have a reason why they want to go.

The **Chairman**. Well, if you like to go hunting for ducks——

Dr. **Fickenscher**. North Dakota is the place to go, yes.

The **Chairman**. During season for an hour and a half or two hours before you go down to the clinic, you might do that.

Dr. **Fickenscher**. Yes. Devil's Lake, North Dakota is actually a great place for that particular kind of person.

Senator **Burdick**. The duck factory of America.

The **Chairman**. However, as a matter of fact, most physicians when they decide after they graduate and after they get through with their residency where they are going to practice, they are not going to select a place where you are paid less for doing the same thing.

Dr. FICKENSCHER. I agree.

The CHAIRMAN. That is the only question I have. I want to thank you very much for your testimony. It is very astute testimony, by the way, Doctor, and very helpful to us. Your entire statement will be made part of the record in addition to your comments with which you have augmented your statement.

Dr. FICKENSCHER. Thank you.

The CHAIRMAN. Senator Burdick.

Senator BURDICK. Doctor, you have described a specific type of educational program called a deployment program. How do you think we can encourage the development of deployment programs at the Federal level?

Dr. FICKENSCHER. Well, one of the things that I really believe is that the deployment model is a very effective model for meeting rural manpower needs. It has been shown time and again that it works.

Unfortunately, no emphasis is placed on that particular approach towards the training of nurse practitioners or P.A.'s. The Federal Government, in its support of nurse practitioner and P.A. programs, I think, could emphasize that type of model as an approach for training practitioners for rural areas.

So, I think there are some things that could be done. I don't know that we necessarily need law to do that. I think that if the Health Resource and Service Administration potentially could emphasize that as part of its criteria that we would see more development of those types of programs.

Senator BURDICK. You provided statistics about the current and predicted nursing shortage. This shortage of professional providers is of tremendous concern to me. It has a direct implication for access to quality care. Considering how ill patients are today, an inadequate number of well qualified nurses may spell disaster.

You may remember the physician shortage that occurred in the 1960's. How do you think the current nursing shortage compares with the physician shortage of days gone by?

Dr. FICKENSCHER. I think that the nursing shortage is actually, when it gets full blown which will probably be in another couple of years, may in fact be more significant and harder to deal with than the physician shortage. I also believe that nursing programs, specifically baccalaureate programs, need to recognize, just like we in medicine have recognized, that you can't take one type of training program and apply it and expect people to go into rural practices.

We do need programs that emphasize rural nursing, that emphasize the nurse generalist if we are to have an impact in training sufficient numbers of nurses to go into rural areas. A bias that I have is that we are making some mistakes in nursing by not encouraging that early on as we try to work on this particular problem.

Senator BURDICK. I am going to ask you this question just for my information. Is there a nursing shortage in the larger cities?

Dr. FICKENSCHER. Well, there is in some of our metropolitan areas. There is a real substantial shortage of nurses, for example, in New York, Los Angeles, San Francisco, et cetera. As a matter of fact, that is where the shortage first showed up was in the urban areas.

But what is happening is that as the urban areas have gone into fairly intensive recruitment programs, offered higher salaries, they are slowly pulling the nurses, particularly the younger graduates, away from rural areas. I think that as we look at the problem over the long term, it is going to be a much harder problem to deal with in rural areas than it is in urban areas over the long term.

Senator Burdick [acting chairman]. Thank you, Doctor.

The Senator from Minnesota, do you have any questions?

Senator **Durenberger**. Yes, I have a couple or three questions, Mr. Chairman. Thank you.

First, let me compliment you on your statement. Your oral statement was good, too, but your written statement is terrific.

First, on the issue of reimbursement of the hospitals, I had proposed a year or so ago that on our way to national averaging that we select a rate reimbursement for rural hospitals that would be 80 percent of the SMSA average for everybody else. Then, I looked at the Physician Payment Review Commission report in which they deal with some of these issues, and it looked to me as I looked at some of that data there for physicians that—and they divided Part B up in the large cities over 1 million and the small cities, SMSA's like Fargo, Moorhead, and then large rural and small rural.

I think the information that I saw there was it is the cities over 1 million that are off the wall, that the Fargos and Moorheads are not that far from the Fergus Falls or the Willistons and are from the very small communities. So, wouldn't you say that, as a minimum, we ought to very quickly move in the direction of averaging the two classes of rurals and the small urban by bringing both the rurals up to the small urban average? Wouldn't that be an appropriate step?

Dr. **Fickenscher**. Yes, I think that would be very appropriate. You are exactly right. When you look at that data, it does show, for example, if you are a physician in New York City, your costs are considerably higher because of overhead and things like that, but those other "urban" areas have costs very similar to what rural physicians are facing.

So, bringing those two together, I think, would be very wise.

Senator **Durenberger**. But, politically also—and we have to deal with this all the time—the OBRA last year in the continuing resolution demonstrated the fact that until some change occurs in who runs committees on both sides, particularly on the House side, we aren't going to be able to bring this disparity together, because those over 1 million communities with their big hospitals are shifting a lot of money out of Medicare and into indigent care, refugee care, very expensive payments to physicians and other specialists, and they won't give it up.

However, they happen to chair the right committees around this place so that they continue to get more money than Minneapolis-St. Paul gets or some other smaller over 1 million.

So, the political reality is that if we continue this process of trying to bring down the folks that are getting paid three times as much as rural folks in order to pay the rural folks, we probably aren't going to make that. I have just been thinking that maybe the best thing is we have to put a few more bucks into Medicare, then, if we want to satisfy this problem.

If we can't get it away from the folks who are getting too much and shifting Medicare dollars into other services, then at least we ought to bring all of those rural North Dakota, Minnesota, California communities up to the level of our small or under 1 million population urbans. That would go a long way, wouldn't it, to rectifying some of this disparity?

Dr. **Fickenscher**. Yes, it would clearly go a long way. I think when you start to look at it, clearly, those dollars should go to the rural side, because there is a deficiency there.

We tried to do a little bit of that this last year on the hospital side where you increased the reimbursement for rural hospitals at a greater rate than urbans, but if we go at 1.5 or 2 percent a year, that is not going to make it over the long term.

Senator **Durenberger**. Let me ask you another related question which is this business about taking from the high bucks to the low bucks. We ain't seen nothing yet until we get to the physicians. When we get to the RVS, relative value scale, next year, the physician payment commission, I think appropriately, is going to say that the reason we can't get family practitioners and primary care people to stick in these rural areas is the disparity between what they get paid and what some of these high priced specialists get paid is very large and that one of the things we ought to do is raise, like we did in OBRA, the payments to them but at the expense of the high priced specialist.

Now, how do you think we are going to fare here in this process when we say to the high priced sub-specialties that they are going to have to give up a little bit in order to help out family and primary care physicians?

Dr. **Fickenscher**. That is a real good question, Senator Durenberger. I think that is going to be an interesting battle.

I am a family physician, so I am obviously biased towards family practice. I believe that family physicians provide a very important service in health care and that that service needs to be compensated at an appropriate level and that, unfortunately, our reimbursement system evolved from the late 1800's and early 1900's, and it was a very procedure oriented system. In fact, our reimbursement system today reflects that.

Yet, medicine has shifted considerably. As we look at health care, we need to realize that the reimbursement system drives the whole health care system. If we want to encourage primary care, if we want to encourage non-invasive kinds of approaches to health care, lower cost, if you will, then we need to have a reimbursement system that supports that.

So, I would be on the side of the fence and probably some of my ophthalmology colleagues, et cetera, would be very opposed to what I am saying, but I do think that we need to have higher reimbursement for primary care physicians.

Senator **Durenberger**. One of the things we did in 1983 when we put in a prospective payment system—and that is what an RVS is going to be—for hospitals is we added mandatory assignment. We said, that is it. If you want Medicare patients in your hospital—and, of course, everybody has to have them—you take these dollars.

Now, what is your view if mandatory assignment came along with RVS for physicians in this country? Do you think that would discourage—let me say where I am coming from. I fear that it would discourage practice in rural areas. I think that data shows that, at least in my State, the predominance of physicians who won't take assignment are in rural areas. Not that they don't from time to time take assignment, but generally speaking, they don't.

So, that is where I am coming from, but how do you view the matter of assignment?

Dr. FICKENSCHER. I would be very concerned about mandatory assignment unless you can get those reimbursement rates up at a comparable level. If they were comparable, then I think you could then look at mandatory assignment as a possibility. But until that happens, I think you are right. It may discourage——

Senator DURENBERGER. Well, what do you hear from rural physicians? I mean, if you have a situation where a doctor in Miami can get three or three and a half times as much as a doctor in a small town in Minnesota or North Dakota and the political reality is you are never going to get those docs up to Miami, don't you think the fear of most physicians and other people would be that if you take mandatory assignment that they are going to start bringing the rates down, that they are not going to go up?

Dr. FICKENSCHER. That is the fear of a lot of rural docs. That is the reason everybody is watching the debate and trying to see what is happening on the reimbursement level.

As I said, maybe the political realities are that you can't bring the rural practitioners up. If that is the case, then we have a real problem, and I don't have a solution.

Senator DURENBERGER. The last thing is something I am not going to ask you to respond to because time is running short, but I would like your views as part of this record on the issue of quality and outcomes. This afternoon at 2:00 o'clock in the Finance Committee, we are going to be dealing with those issues.

I think one of the salvations for rural practitioners, one of the salvations for nursing, is if we could come up with some outcomes measurements so we can get off this fetish of just because it expensive, it must be good and try to find ways to reward people for quality in their outcomes. If you have some views on that—I didn't see that necessarily in this paper, but——

Dr. FICKENSCHER. Yes, I didn't prepare that.

As a matter of fact, we are working on a project in Minnesota with the Northern Lakes Health Care Consortia trying to develop a model project to develop quality outcomes for rural areas, recognizing that we need to do that in rural areas so that we can state very clearly what quality outcomes will be.

Senator DURENBERGER. Thank you.

Thank you, Mr. Chairman.

Senator BURDICK. Senator Wilson?

STATEMENT OF SENATOR PETE WILSON

Senator WILSON. Thank you, Mr. Chairman.

Doctor, I heard you make a comment that one of the most severe problems that rural health care faces is a shortage of an adequate supply of nurse practitioners. I believe I heard you say that there are certain communities that are suffering largely in the non-rural areas from a loss of otherwise highly qualified foreign trained nurses and foreign nurses. Maybe I misunderstood you.

Dr. **Fickenscher**. Yes, I didn't say that, but——

Senator **Wilson**. I thought I heard you make reference to Los Angeles and San Francisco. That has been, I think, the experience in my State.

One of the more common complaints that I hear from physicians in both public health and private practitioners is that there is a critical nursing shortage and that it is being artificially aggravated, at least in States like mine, by the inflexibility of certain immigration regulations that are causing highly trained and highly proficient and desperately needed nurses to be forced to return to their home countries, particularly the Philippines, the British Isles, Mexico, because they have not been able to satisfy the requirements that would permit them to stay past a period of about four years.

I don't know what bearing that has on health care in the rural areas, but it seems to me to be a very real problem and one where we are, because the right hand does not know what the left hand is doing, the right hand is, in effect, chopping the left.

Dr. **Fickenscher**. I think, Senator Wilson, in places like California, that is a problem where foreign trained nurses do have to go back to their home country. I guess I would turn back to our lessons of the 1960's. One of the things we tried to do back in the 1960's was to solve the physician manpower problem by opening the gates, if you will, and letting foreign physicians come into the United States.

My personal philosophy is that I believe that we want to allow people to come into this country, and I have always held that view. At the same time, I think it is an inherent injustice for the United States to solve its particular manpower problems by draining away individuals from countries like the Philippines.

For example, back in the 1960's, it was not uncommon for an entire graduating class of physicians to move to the United States. To the extent that that is happening, I think that we do an injustice to those countries that have very limited resources for training health professionals by really draining them away for our particular needs.

We can clearly address the problem if we take the right approach towards training and if we make some changes in our reimbursement system, et cetera. So, I think it does cut a little bit both ways.

Senator **Wilson**. Well, I think it is admirable that you are focusing on the problems of other countries. The concern that I have is that—and it may be only a short-term problem, although my advice is to the contrary, that the problem of a shortage of nurses is bad and growing worse and has been for some time.

Dr. **Fickenscher**. Yes, it is.

Senator **Wilson**. And that, in fact, that is what has brought a number of these health care professionals from foreign countries. So, I would have to say that I think that we perhaps shouldn't be overly concerned about trying to allocate on a worldwide basis what seems to be in short supply.

I would agree that there is a need to encourage the development of programs that will engender a greater supply, but I find, in talking with the health care professionals in my State, that this is a critical problem and it is one that is in fact being aggravated rather severely.

Dr. **Fickenscher**. Well, it is my understanding that California has probably one of the most significant problems with the nurse shortage. It is really hitting that State particularly hard along with New York and a couple of other places.

Senator **Wilson**. Thank you.

Thank you, Mr. Chairman.

Senator **Burdick**. The Senator from Wyoming.

STATEMENT OF SENATOR ALAN SIMPSON

Senator **Simpson**. Mr. Chairman, I thank you very much.

I don't have any questions of this gentleman. I want to thank the chairman for calling this the second hearing in a series on the rural health care issue. It is such a critical one for many States, including that of the chairman and mine in the smaller rural State of Wyoming.

Certainly, provisions of health care are changing so rapidly. The town doctors have been replaced by the high tech and the higher expectations of what a physician can do. I think that is the thing.

Now, we are replacing parts of the human anatomy that we would never even have thought possible 10 or 20 years ago. The capability to preserve and extend life is remarkable. Yet, it all comes with a high price tag, and it is a big one.

I know there are those here at this table—Senator Durenberger has worked tirelessly on this. Pete Wilson and Senator Burdick also. But now it is time to take a good fresh look.

In the 1970's, we pumped money in for health providers. We provided training. We said go learn this and then go to the rural area and promise you will come back and we will hold you in indentured servitude if you don't, and it didn't work.

Now we have nursing shortages. I think few of us realize that we just extended for a year special immigration policies for nurses because we can't get domestic nurses in the United States. We are using foreign nurses who were here on a temporary basis, and now we have increased their status for a year. That doesn't solve our problem.

Some say the Medicare costs will exceed the defense budget by the year 2000. We are headed that way. Long-term care—we have to address that. The catastrophic health law we put together and other forces at work——

I have an opening statement and would like to include that in the record.

Senator **Burdick**. It will be received.

Senator **Simpson**. It has to be a careful blend of public and private resources, and here we go. We have much to do, serious questions, and we have to get rid of this differential between urban and rural. It didn't pan out the way that we thought it would when we put it together, and that is with regard to Medicare and health care finance and the whole works.

I look forward to working with the chairman and others on the Senate Rural Health Caucus and from this committee. Many of us are sitting right here at this time.

So, thank you, Mr. Chairman. I appreciate Senator Melcher's calling this hearing.

[The prepared statement of Senator Simpson follows:]

STATEMENT FOR SEN. ALAN SIMPSON

JULY 11, 1988 HEARING ON RURAL HEALTH PERSONNEL

John, I thank you for calling this, the second in the series on rural health issues in the Aging Committee. This is such a very important issue for our rural communities.

Delivery of health care is changing rapidly in this country. The "town doctor" is being replaced with higher technology and higher expectations of what the physician can do. Our capacity to preserve and extend life is most remarkable. For example, we can now transplant and replace parts of the human anatomy that we would never have thought possible just ten or twenty years ago. Yet, this kind of care comes with a price tag -- a big one.

We are all now familiar with the figure of over $500 billion being spent on health care alone in this country, over 11 percent of our Gross National Product -- and health care expenses will only continue to rise. Some are predicting that Medicare costs will exceed the defense budget by the year 2000, and that is even without figuring in the cost of new programs. Long-term care and the catastrophic health law will also run up the tab.

Other forces are also at work that will change health care delivery. Highly sophisticated health care technology requires highly skilled personnel to run it. Inflated expectations of what medicine can do and the idea that a patient is entitled to a "perfect outcome" have contributed to increased litigation and rising liability insurance premiums. All these forces and energies are driving the health care system in this country today.

In the face of all this change, we need to determine the proper role of the federal government in the health care system. The health care needs of our nation will always increase. However, the resources at the federal level are not unlimited.

The debt limit through May of 1989 for the federal government is currently $2.8 trillion. The federal budget for 1988 alone is about $1.1 trillion. Of that, $156 billion represents deficit spending, for which there is no revenue.

In the face of all this change and the limits on resources at the federal level, what are the solutions to the problems of access to care and the availability of health care providers in our rural areas? That is a very important question which we should pose in this set of hearings. We need to discuss some creative solutions to these most difficult issues.

Our policy on health manpower issues should be a careful blend of public and private resources, balancing the needs and responsibilities of all participants in the health care delivery system. I would be most interested in some of the private sector initiatives that we will hear about today, that will help us improve rural health manpower.

Our record up here, in the halls of Congress and the federal government, is not all that great. In the 1960's and 70's the federal government, in its infinite wisdom, pumped billions of dollars into the education of health care providers. These funds were intended to increase the availability of health care in rural and severely underserved areas. We figured more bucks would solve any manpower shortage, and maybe even lower health care costs if there were just more "docs" out there.

Well, there are now more doctors, dentists and nurses than ever before, but we are still having difficulty in providing adequate health care services. The problem, it turns out, was really a "maldistribution" of health care providers, rather than a shortage. In addition, the cost of health care has continued to increase -- in spite of federal health manpower initiatives. This has resulted in some very serious questions about existing federal programs in providing adequate access to health care services.

It is therefore important for us to discover new and better ways to ensure the adequate provision of health care services in rural areas. I am committed to working with you, Mr. Chairman, and the other fine Senators here, who are also members of the Senate Rural Health Caucus: Senators Heinz, Cohen, Pressler, Grassley, Domenici, Durenberger, Pryor, Breaux, Shelby, and Reid. It is important to work together on these issues if we are to find some honest and workable solutions to the pressing needs of health manpower in our rural communities.

Senator **Burdick**. Are there any further questions from any of the members?

[No response.]

Senator **Burdick**. If not, we thank you for appearing today.

Dr. **Fickenscher**. Thank you, Senator.

Senator **Burdick**. Our next witness will be David Sundwall, M.D., Administrator of the Health Resources Services Administration.

Welcome to the committee.

STATEMENT OF DAVID N. SUNDWALL, M.D., ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, DHHS, ACCOMPANIED BY JEFFREY HUMAN, DIRECTOR, OFFICE OF RURAL HEALTH POLICY

Dr. **Sundwall**. Thank you, Mr. Chairman and Senators.

I am delighted to be here today and be the final witness at this important hearing. I realize the hour is late, and I will try to be brief. I will ask that my written testimony be inserted in the record, but I will try to give a summary.

Senator **Burdick**. It will be received.

Dr. **Sundwall**. I have with me Mr. Jeff Human who is the Director of the Office of Rural Health Policy. He is sitting to my right here, and I brought him so you would all get to know him. He has a very important responsibility with the new focus for rural health in the Public Health Service and on the part of Secretary Bowen. Also, in case you have any hard questions. He will have the answers.

We share your concern about the financial stability of hospitals and the chronic shortage of health professionals in many rural communities throughout the country. These, in fact, are the highest priorities of our Office of Rural Health Policy.

In looking at these problems, we are mindful of the fact that the percentage of elderly Americans living in rural communities is high and is growing, and we very much applaud the interest of the committee in working to preserve access to quality health care for all rural Americans.

There are many good reasons to be concerned. Rural communities continue to have problems in recruiting and retaining physicians in spite of the fact that there may soon be an aggregate oversupply of physicians in our country. Diffusion of physicians into rural areas has taken place but it is happening very slowly and is certainly not happening uniformly across the country.

Dr. Fickenscher in his previous testimony referred to a study done at the University of Wisconsin at Madison that showed that small rural communities between 1975 and 1985 had a physician population ratio that grew less than half as fast as for the nation as a whole.

We are especially concerned that there has been an apparent shortage of physicians in family practice and primary care, and that shortage, of course, has profound implications for rural areas.

So, what are we doing to improve the situation? Over the past 25 years—I think it is important that you as Senators pause to remember—our agency's Bureau of Health Professions and its predecessors have invested about $8 billion in Federal initiatives to help meet the nation's health profession and nurse education needs. At first, the main objective was simply to increase the overall number of providers.

In recent years, we have turned our attention to more specific objectives. One of these objectives has been to improve the supply of health care personnel in rural and under-served areas.

Along with other programs, the Bureau of Health Professions continues to provide assistance for training of family practice physicians and other primary care specialists. These medical specialists are, of course, critical to rural areas, and our programs have been instrumental in steering some individuals towards practice in those areas.

I would add that in the field of nursing, the Bureau of Health Professions has provided special project assistance in underserved areas for continuing education for rural gerontology nurses and the training of LPN's in order for them to become registered nurses. A number of our nurse practitioner/nurse midwife training programs have a rural focus, and assistance has also been provided for advanced education of nurses to serve as rural community health nurses and rural health clinical specialists.

I know you have heard testimony earlier today about the National Health Service Corps which has, over its ten years, placed about 15,000 physicians in under-served areas. In recent years, most placements have been in rural areas. Congress has recently changed the Corps in a very favorable way, we believe, and that is that we are now in the process of implementing a loan repayment program which we believe will be less expensive for taxpayers and more effective in placing health professionals in under-served areas.

A portion of the funds appropriated for this program will go to States for their own loan repayment programs, and the rest will be disbursed directly by the Health Resources and Services Administration.

The way it works is that we will be able to provide up to $20,000 per year in loan repayment in return for service in an under-served area. A participant must commit for at least two years to serve in a designated manpower shortage area.

We also support through our agency, as you know, community and migrant health centers. About half of all of the funds for community health centers go to rural clinics. Of course, almost all of the funds for migrant health centers are in rural areas.

These programs, the National Health Service Corps and our community and migrant health centers, between them provide for the basic care of about 6 million Americans per year. More than half of them reside in rural areas.

Another important program we run through our agency is area health education centers called AHEC's. This program is designed to get interdisciplinary training for a broad range of health professionals in outlying areas away from the traditional medical school or health professional schools.

Under this program, medical and osteopathic schools are aided in establishing training centers apart from their main campuses, and 13 of our 19 AHEC programs are involved either wholly or in part in rural areas. In such States as North Carolina and Ohio which have AHEC programs, they have documented great success in recruiting and retaining physicians and other health professionals for rural areas.

We also fund geriatric education centers. While their focus is not entirely rural, we have supported through our centers a number of training programs with a rural focus.

The University of Mississippi, the University of Utah, and the University of North Dakota all have special concern for the needs of rural populations.

In addition to these ongoing programs, we are about to announce a rural health medical education project which was authorized by Congress last year to assist resident physicians in obtaining field experience in rural areas. Under this program, sponsoring teaching hospitals will make arrangements with small rural hospitals to provide for residents' rotations of up to three months.

We have been working closely with the Health Care Financing Administration because they will have to pay the bill for part of the residency training, but we will be managing that project.

Also, the department will soon begin funding a three-year demonstration project to establish an interactive communications system and data exchange between teaching hospitals and rural physicians and other health professionals. In addition to providing instruction and continuing medical education, this project will examine methods for providing a two-way video consultation in clinical settings.

The demonstration could result in new ways to improve the recruitment and retention of physicians in rural areas by decreasing their sense of isolation and enhancing the quality of care they can provide.

Our Office of Rural Health Hospitals has initiated two new activities involving rural health manpower which will compliment the things I have just mentioned. The first is that we will be awarding grants to three to five rural research centers this summer. We expect that they will be evaluating new approaches that rural communities might take to recruit and retain physicians and nurses and other health professionals.

The Office of Rural Health Policy will also provide staff for the newly established National Advisory Committee on Rural Health. This committee has been created to advise the Secretary of HHS and to make recommendations on a broad range of rural health issues.

It has 18 members, including hospital administrators, physicians, nurses, other health professionals, and public representation. The committee will be chaired by the former Governor of Iowa, Robert Ray, and we expect that rural health manpower issues will certainly be high on their list of agenda items to consider.

I would just like to mention that we are beginning to see a great deal of interest in the Rural Health Care Clinical Services Act which was initially passed by Congress in 1977. The original law allowed for Medicare and Medicaid to reimburse rural health clinics for services provided by physicians' assistants and nurse practitioners even though they weren't supervised by a physician. In fact, Congress amended this act last year to increase the reimbursement rate from $32 to $46 per encounter, and we hope that this will encourage the establishment of more rural clinics.

Mr. Chairman, you have asked that I comment on the activities of another group in the department, the Commission on Nursing. This was established in January to advise the Secretary.

Although the initial or interim report which they provided does not make recommendations, it does document that indeed there is a nursing shortage, and this affects rural hospitals although to a lesser extent than urban hospitals.

Before concluding, I want to emphasize that rural health manpower is as much an issue for State and local communities as it is for the Federal Government. I have had the pleasure of serving on the department's Council on Graduate Medical Education which has found many successful programs initiated by both State governments and the private sector.

There is evidence, for example, that selective medical school admissions policies in rural States may improve the geographic distribution of physicians. States like North Dakota which Kevin Fickenscher has just mentioned, have used this approach to increase the likelihood that medical students will choose to practice within the State or in under-served areas.

The programs work by granting a preferential treatment to in-State residents or applicants with backgrounds that seem particularly suited to rural medicine. South Carolina and South Dakota also have laudable programs in this area.

There are many other examples of State programs that could be cited. Iowa and Washington State, for example, have medical schools which emphasize community practice and provide opportunities for medical school experience in these settings.

Schools like these graduate a higher percentage of physicians that go into family medicine, general pediatrics, and general internal medicine, the specialties most needed in rural areas. We strongly encourage these efforts and believe that States should play an increasingly important role in health manpower shortage areas.

In conclusion, Mr. Chairman, I want to emphasize again our firm commitment to improving access to high quality health care for all rural citizens. The recent Congressional initiatives that I have mentioned together with ongoing programs in HRSA are effective in helping to reduce health manpower shortage areas. I can assure you that we will continue to seek ways to make these programs work and to work successfully with you.

Thank you for inviting me here today.

[The prepared statement of Dr. Sundwall follows:]

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

BY

DAVID N. SUNDWALL, M.D.

ADMINISTRATOR

HEALTH RESOURCES AND SERVICES ADMINISTRATION

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

I am Dr. David Sundwall, Administrator of the Health Resources and Services Administration. I am pleased to be here today to discuss health professions in rural areas.

With me today is Mr. Jeffrey Human who is the Director of the Office of Rural Health Policy, a unit formally established in my Agency last August to provide a focal point within the Department for coordinating rural health policies and issues.

Mr. Chairman, we share your concerns about the financial stability of rural hospitals and the chronic shortage of health professionals in many rural communities throughout the country. These are the two highest priorities we have set for the Office of Rural Health Policy. In looking at these problems, we are mindful of the fact that the percentage of elderly Americans living in rural communities is high and has been growing. We applaud the interest and commitment of this Committee to the preservation of access to care for these individuals.

There are good reasons to be concerned about the availability of health manpower in rural areas. Many rural communities continue to have problems in recruiting and retaining physicians despite the fact that there may soon be an aggregate oversupply of physicians. While some diffusion of doctors into rural areas is taking place, it is very slow and is not occurring uniformly across the country.

A recent study performed at the University of Wisconsin-Madison showed that in small rural communities between 1975 and 1985, physician-to-population ratios grew at a rate less than half as fast as in the Nation as a whole (14.2 percent compared to 32.5 percent). Moreover, small rural communities continued in 1985 to have physician-to-population ratios less than one-third that of national rates (53 physicians for each 100,000 people versus 163 physicians per 100,000 people).

We are especially concerned that there is an apparent shortage of physicians in family practice and primary care. That shortage has profound implications for rural areas where there are fewer primary care physicians per capita than there are in non-rural areas.

What are we doing to improve the situation?

Over the past 25 years, my agency's Bureau of Health Professions and its predecessors have invested nearly $6 billion in Federal initiatives to help meet the Nation's health professions and nurse education needs. At first, the main objective was to increase overall supply as necessary to keep pace with population growth. In recent years, attention has turned to more specific objectives that have included, among others, improving health care personnel supply in rural and other underserved areas.

Although Federal support for expansion of physician output ended a number of years ago, the Bureau of Health Professions continues to provide assistance for the training of family medicine and other primary care physician specialists. These medical specialty training programs have been instrumental in steering some individuals toward practice in rural areas.

I would add that in the field of nursing, the Bureau of Health Professions has provided special project assistance in underserved rural areas for improving the skills of LPNs. A number of the nurse practitioner and nurse midwife training programs supported by the Bureau have had a rural focus. Assistance also has been provided for advanced education of nurses to serve as rural community health nurses and rural health clinical specialists.

Another of our programs is the National Health Service Corps (NHSC), which has placed nearly 15,000 physicians in underserved areas. In recent years, most placements have been in rural areas.

The NHSC improves the delivery of health manpower resources to areas, populations, and facilities which cannot otherwise recruit and/or retain health care providers. This is accomplished through the appropriate placement and delivery of health professionals and resources in health manpower shortage areas (HMSAs). As a result of increases in the Nation's supply of health professionals and the successful placement and retention of NHSC providers, the remaining shortage areas have been reduced to 1,931 primary care and 788 dental shortage areas. The NHSC currently has 2,511 assignees staffing 1,309 sites. Of these, 65% of the staff and 75% of the sites are located in rural areas.

The recently enacted loan repayment program will be helpful in attracting additional health professionals or replace those now serving in shortage areas across the Nation. This program will recruit physicians in residencies or who are already licensed, to serve in health manpower shortage areas which cannot otherwise attract and support a doctor in exchange for repayment of a portion of their loans for medical education. Such individuals are usually more certain about their career goals than the NHSC Scholarship program obligors, and therefore, the incidence of default on service obligations should be reduced.

The Health Resources and Services Administration also supports community and migrant health centers (C/MHCs) which provide direct access to primary care services for medically-underserved populations. About 50% of all CHC grant funds are directed to rural CHCs. As expected, most of the MHCs are located in rural areas.

C/MHCs provide prevention-oriented comprehensive primary health care services to medically underserved populations in their communities. The clinical team directs the delivery of services within a framework which recognizes that people progress through five stages of life: prenatal, pediatric, adolescent, adult, and geriatric.

Last year, CHCs delivered primary care services to approximately 5.5. million persons, about half of whom live in rural areas. Approximately 64% of those served were members of minority groups: 31% Blacks; 28% Hispanics; and 5% others. Forty-five percent of the CHC users were children under age 20; 46% were age 20 to 64; and 9% were 65 or over. About 60% had incomes under the poverty level and another 25% were between 100% and 200% of the poverty index.

The migrant health program provides grants which help support 122 health centers which serve an estimated 500,000 migrant and seasonal farmworkers and their families annually. This group is composed of approximately 50% Hispanics; 35% Blacks; and 15% White, Asian, and others.

These two programs - The CHCs and MHCs - between them provide basic day-to-day primary care to about 6 million Americans. More than half of these people reside in rural areas.

The Bureau of Health Professions' Area Health Education Center (AHEC) program also play an important role. This program was designed to develop interdisciplinary training programs in outlying areas, including rural areas, where there are shortages of health personnel. Under the program, medical and osteopathic schools are aided in establishing training centers apart from the main campuses of the schools. In Fiscal Year 1987, 13 of the 19 AHEC programs were involved either wholly or in part with rural health activities. States such as North Carolina and Ohio that have an AHEC program have documented increasing success in recruiting and retaining physicians and other health professionals, including personnel for rural areas.

The agency's Geriatric Education Center program although not targeted directly towards meeting needs in rural areas, has supported a number of centers that provide interdisciplinary training for health professionals who will serve populations in rural areas. Programs such as those at the University of Mississippi, the University of Utah, and the University of North Dakota, have had a special concern for the needs of rural populations.

In addition to these ongoing programs, we are about to announce a rural health medical education demonstration project which was authorized by Congress last year to assist resident physicians in obtaining field experience in rural areas. Under this program, up to four sponsoring teaching hospitals will make arrangements with small rural hospitals to provide for resident rotations of up to 3 months in the rural hospitals. We have been working closely with the Health Care Financing Administration on this project since Medicare will pay part of the direct medical education costs that will be incurred.

Also, the Department will soon begin funding a 3-year demonstration project to establish an interactive communication system and data exchange between teaching hospitals and rural physicians. In addition to providing instruction and continuing medical education, this project will examine methods for providing two-way video consultations in clinical settings. The demonstration could result in new ways to improve the recruitment and retention of physicians in rural areas by decreasing their sense of isolation and enhancing the quality of care that can be provided. The project may also contribute positively to the financial condition of participating hospitals.

The Office of Rural Health Policy has initiated two new activities involving rural health manpower that will complement the other programs and activities I have mentioned. Before the fiscal year is over, the Office will award grants to support 3-5 Rural Health Research Centers around the country. We expect that some of these centers will be evaluating new approaches that rural communities may take to recruit and retain physicians, dentists, nurses, and other health personnel. The results of their work will be disseminated to a wide audience.

The Office of Rural Health Policy will provide staff support to the National Advisory Committee on Rural Health which has been established by the Secretary to advise him and make recommendations on rural health issues. The Committee consists of 18 members, including rural hospital administrators, rural physicians, nurses, and other health professionals. The Committee will be chaired by former Governor Robert Ray of Iowa. We expect that rural health manpower issues will be high on the committee's agenda. We also expect that the Committee will be an action-oriented group that will move quickly to make recommendations to us and, perhaps, to the Congress as well.

I should also mention that we are beginning to see a great deal of interest in the Rural Health Clinic Services Act passed by Congress in 1977. The original law allows for Medicare and Medicaid reimbursement to rural health clinics for services provided by nurse practitioners and physician assistants even when the services are not provided under the direct supervision of a physician. An amendment to the law enacted last year raises the basic medical encounter rate for rural health clinics from about $32 to $46. We hope this will encourage the establishment of more such clinics in rural underserved areas around the country.

Mr. Chairman, you asked that I comment on the activities of another group within the Department - the Commission on Nursing - which was established in January to advise the Secretary and make recommendations on nursing shortage issues. A preliminary report from the Commission will be sent to the Secretary in a few weeks.

My understanding is that the Commission has found a real and significant shortage of nurses that is affecting rural hospitals and other nurse practice settings. We have not yet had an opportunity to review this report and, thus, cannot comment at this time.

Before concluding, Mr. Chairman, I want to emphasize that rural health manpower is as much an issue for States and local communities as it is for the Federal Government. I serve on the Department's Council on Graduate Medical Education which has found many successful programs initiated by both State governments and the private sector to address the issue. There is some evidence, for example, that selective medical school admission policies in rural States may improve the geographic distribution of physicians. Selective admissions in States like North Dakota have been used to increase the likelihood that medical students will choose to practice within the State or in an underserved area of the State. These programs work by granting preferential treatment to in-State residents or applicants with particular backgrounds and interests.

South Carolina has a program which mimics the NHSC Scholarship program at the State level. Physicians receive support for medical school and provide service in underserved areas in return.

South Dakota recently has initiated a new loan repayment program much like our new Federal program. One different feature of the State's program is that both the State and local communities within the State contribute funds to support the program.

There are many other examples of innovative State programs that could be cited. Iowa, Minnesota, and Washington, for example, have medical schools that emphasize community practice and provide opportunities for medical school experience in community practices. Schools like these graduate disproportionate numbers of physicians who go into family medicine, general pediatrics, and general internal medicine, the specialities most needed in rural areas. They also retain a high proportion of these physicians in their States and in neighboring rural States.
We strongly encourage these efforts and believe that States should play an increasingly important role in addressing the shortages of health manpower in rural areas.

In conclusion, Mr. Chairman, I want to emphasize again our firm commitment to improving access to high quality health care for all rural citizens. The recent congressional initiatives I have mentioned together with ongoing programs in HRSA are effective in helping to reduce the health manpower shortage in rural areas. I can assure you that we will continue to seek ways to make these program even more responsive to the unique needs and circumstances of rural communities.

The CHAIRMAN. Dr. Sundwall, you were here earlier when I asked Dr. Fickenscher what the comparison was for the charge for giving a Medicare patient a flu shot in a rural community as compared to a metropolitan community, and he said, by an large, they would be paid less. Since income plays a significant role in the decision of where somebody chooses to practice medicine or practice law or practice dentistry or practice anything, what do you think of that? Do you think Congress is absolutely haywire to retain a policy that provides lower reimbursements for a practicing physician in rural America?

Dr. SUNDWALL. I see no justification for physician reimbursement to be less in a rural area than in an urban area. I think justification has been made based on labor costs and what have you, but I think there is increasing evidence that the cost of living in rural areas really is not as different as it is in some urban settings.

The CHAIRMAN. Thank you, Doctor.

Senator Burdick.

Senator BURDICK. Again this year, the Administration proposed decreasing funding for the National Health Service Corps. Further, you are proposing phasing support out entirely.

How is that going to affect access to physicians in rural areas?

Dr. SUNDWALL. Sir, we are certainly not proposing phasing out the National Health Service Corps. We have got a new way of doing business with the loan repayment program. In fact, the Administration is seeking full funding for the field costs of operating the Corps in the next annual budget, and we are also seeking a limited amount of money for loan repayment.

What we have not sought is new scholarships. In fact, there have been very few scholarships appropriated by Congress in this decade. Those have been almost exclusively limited to students with extreme financial need or minority students.

The reason we are not seeking renewal of the scholarship program is because the pipeline for that is so long. You give it to students, say, in the first year of medical school training, and you don't get a candidate that you can place in an under-served area for about seven or eight years after their training.

What we would much prefer to do is get a resident doctor in training or other kind of health professional near the end of their training. Then, in return for their willingness to serve in an underserved area, we will help them relieve the costs of their education.

Senator BURDICK. Then we can still rely upon Corps service at Indian reservations in the days ahead, can we?

Dr. SUNDWALL. Yes, indeed. In fact, we collaborate very closely with the Indian Health Service in determining which of our assignees can go. They have their own separate budget for loan repayment at the Indian Health Service which I think is entirely appropriate.

Senator BURDICK. That is kind of an over statement then that you are going to close out the Corps. That is not quite right.

Dr. SUNDWALL. Not quite right, no. That is a premature funeral. We are interested in keeping that going.

Senator BURDICK. Does the Office of Rural Health Policy have sufficient financial and administrative support to carry out its duties?

Dr. **Sundwall**. Well, I won't ask Jeff that. He is in charge of it. I better answer that before he tells you.

Senator **Burdick**. All right, Jeff, tell us.

Dr. **Sundwall**. Go ahead. You are in charge of that. What is the answer?

Mr. **Human**. We have been very pleased with the support that we have gotten from the Health Resources and Services Administration during the past year. We are a new office. We were authorized, but there is no specific appropriation for us except for one of our activities, the grant program for research centers.

So, the Health Resources and Services Administration under Dr. Sundwall has provided for all of our staff salaries and our office space and all of the other costs associated with our doing business. The Health Care Financing Administration has chipped in as well and is providing support for two of our positions.

Dr. **Sundwall**. If any of you are on the Appropriations Committee, I will just point out that it has put a crimp in our operating staff budget for HRSA, but we are giving them the resources they need.

Senator **Burdick**. That is fine. Does HRSA have the legislative authority to use National Health Service Corps financing to support and place nurses in medically under-served areas?

Dr. **Sundwall**. We certainly do have the authority to do that. Given the limited funds, we have focused primarily on providers who can do obstetrical services, family physicians and obstetricians, but we have the legislative authority to provide for nurses, nurse practitioners, nurse midwives, the whole range of health professionals.

Senator **Burdick**. Well, maybe you have answered this, but what role do you see our other branches of government playing to assist medically under-served communities recruit and retain needed nurses?

Dr. **Sundwall**. There is a whole range of activities going on to increase the recruitment. They are both in Indian Health Service and the National Health Service Corps. By the way, I think the background material we can provide for you will show we have had some successes.

I think that part of what Senator Melcher was getting at is the question of why people would work for less money, I think there is a kind of corny thing to talk about, and that is altruism in public service. I think that we are getting back to a time when a lot of young people in the health professions are looking for an opportunity to do public service, and that includes under-served areas which I think will make our recruitment efforts more successful than they have been previously.

Senator **Burdick**. I get back to age-old question, can you do a better job if you have more money?

Dr. **Sundwall**. Sure. [Laughter.]

Senator **Burdick** [acting chairman]. The Senator from Minnesota.

Senator **Durenberger**. Thank you, Mr. Chairman.

Both of these witnesses either are from Minnesota or have Minnesota connections. That is why they are such soft touches.

David, let me ask you just one question that hasn't been touched on yet except in your statement and that briefly. That is what I think is called the Office of Geriatric Education. I wonder if you can give us—I know that is not directed urban-rural, and yet it strikes me as something that is terribly important to this country that we get about training people for the specific problems of the older Americans.

Could you give us just a little sense of direction and where you are headed and where the emphasis is being placed in that particular area? Again, what isn't being done now that perhaps we ought to be doing in the area of geriatric health education?

Dr. SUNDWALL. Well, we have a pretty good story to tell there. Over the past several years, Congress has authorized the funding of geriatric education centers, and their focus is indeed multi-disciplinary. It is not a medical oriented model. It is doctors and nurses and allied health professionals.

In some schools, they are funded through the medical schools. In some, they are in the schools of nursing. Back in Utah where I am from, the school of nursing runs their geriatric education program, and that is one that I mentioned in my testimony along with others that have a specific rural focus.

As you all know, the numbers of elderly in rural areas is disproportionately higher than in urban areas. So, they have a real responsibility to take care of older people.

I am also pleased to report that we work almost hand in glove with the National Institute on Aging. Frank Williams and I meet regularly. We don't compete with each other. In fact, we try to make sure that everything we do they know about and vice versa.

So, it is a very nice complementary effort, I think, to improve the capability of our health professions students in training to care for the elderly.

Senator DURENBERGER. Thank you.

Thank you, Mr. Chairman.

Senator BURDICK. The Senator from Wyoming.

Senator SIMPSON. Thank you, Mr. Chairman.

It is good to have you here this morning, Dr. Sundwall. I remember your service to our colleague from Utah earlier and to bring your views here. Now, you are the head of the Health Resources Service Administration. That is the branch of HHS that handles programs designed to improved health services.

You deal with all kinds of programs, even dental care and services, I understand, to handicapped and medically compromised patients such as those with chronic illnesses and the elderly.

Have you heard of this program called the donative dental services program?

Dr. SUNDWALL. Fortunately, your staff called me Friday and gave me a heads up on that, so I became aware of it. It sounds like a very laudable program.

Senator SIMPSON. It came from activity of a constituent of mine, as often things do in this peculiar arena. Joe Devine, however, has been the President of the American Dental Association, a very delightful and remarkable man and a friend of nearly a lifetime. He was telling me about the program.

It is most unique where the dentists volunteer at no charge at all, and they provide this service to handicapped and elderly and medically compromised persons. Over 1,000 individuals have received treatment valued at more than $500,000 from 450 volunteer dentists. They deal with mentally retarded, Parkinsonian victims, people whose self-esteem is often equated with just being able to smile without just a snaggle of teeth.

Anyway, they received a grant from the Robert Wood Johnson Foundation, I believe, who do great work. They then want to proceed with it. The start-up costs were contributed by that foundation. The dentists volunteered their services. The local programs pay for themselves. Patients put money into the kitty to take care of those who are unable to receive it.

I think that is a fine example of private sector initiatives that at least this Administration has been attempting to foster, and any new Administration of any faith is going to have to embrace those.

Do you think that funds might be available for the operational costs of such a program, not to compensate the dentists who are doing it in a volunteer way completely but say minimum operational funding of, say, $1 million a year? Would that fit neatly into any existing grant program that you know of?

Dr. SUNDWALL. It really wouldn't right off the bat. I would have to explore with our budget people where it might. I would like to explore that, if I could, with a representative of that program, because in a budget of $1.5 billion, most of that is targeted for either graduate training or area health education or geriatric education or nurse training. It is pretty well carved up into a pie.

However, we could see if there wouldn't be something in our existing training programs. We do training for dentists in our family practice and graduate dental residency programs. I would have to be creative, but I think we might be able to explore that with a representative of that program.

Senator SIMPSON. Well, knowing you and your accessibility, let me have someone contact you and explore that possibility of funding the operational aspects.

Dr. SUNDWALL. I would welcome that.

Senator SIMPSON. Not any payment to the practitioner. That is not what we are talking about.

Dr. SUNDWALL. I understand.

Senator SIMPSON. Then, a final question if I may. You expressed clearly and we have heard from others that it is so difficult to attract physicians to rural areas. You can't force people to work in a rural community. We thought we could. We can't do that.

We may never get physicians to practice in some places for many reasons, personal, professional, money, non-money, just the way it is. My question is, are there any other health care providers that can be attracted into rural areas that can have some level of health care so that there would be at that level, physicians' assistants and nurse practitioners or nurse midwives? Indeed, with what is happening with obstetrical care and that goes back to insurance and goes back to many things, but is that what we could do? Is that possible?

Dr. SUNDWALL. Absolutely. I think part of the responsibility depends on the States and their licensing and credentialing. For example, I used to work on a Utah Medical Association panel that reviewed outlying care in rural areas, and we had a nurse practitioner in Green River, Utah who practiced independently with the exception of a weekly visit from a doctor who flew in to review records and cases.

I believe from my experience of her work that she was as competent and capable as almost any primary care provider I was aware of, physician or not. Certainly, in remote rural areas, the frontier communities that Dr. Fickenscher referred to, I think that is a very viable option.

Senator SIMPSON. Well, I think it is one we have to look at in these smaller States. I just don't know what would prevent some of the most cost effective providers like physicians' assistants and nurse practitioners from practicing in manpower shortage areas. I think there has to be a way to get them into that game.

That is what I hope we can do and we can work on with our Rural Health Caucus.

Dr. SUNDWALL. Good.

Senator SIMPSON. So, I thank you very much, and I appreciate it, Mr. Chairman. Thank you, Dr. Sundwall. It is good to see you again.

Dr. SUNDWALL. Thank you, sir.

Senator BURDICK. The hearing record will be open for two weeks after today to allow follow-up questions and statements to be submitted for the record.

The hearing will be adjourned.

[Whereupon, at 12:43 p.m., the committee adjourned, to reconvene subject to the call of the Chair.]

APPENDIXES

APPENDIX 1.—QUESTIONS AND ANSWERS OF WITNESSES

Item 1

JOHN MELCHER, MONTANA, CHAIRMAN

JOHN GLENN, OHIO
LAWTON CHILES, FLORIDA
DAVID PRYOR, ARKANSAS
BILL BRADLEY, NEW JERSEY
QUENTIN N. BURDICK, NORTH DAKOTA
J. BENNETT JOHNSTON, LOUISIANA
JOHN B. BREAUX, LOUISIANA
RICHARD SHELBY, ALABAMA
HARRY REID, NEVADA

JOHN HEINZ, PENNSYLVANIA
WILLIAM S. COHEN, MAINE
LARRY PRESSLER, SOUTH DAKOTA
CHARLES E. GRASSLEY, IOWA
PETE WILSON, CALIFORNIA
PETE V. DOMENICI, NEW MEXICO
JOHN H. CHAFEE, RHODE ISLAND
DAVE DURENBERGER, MINNESOTA
ALAN K. SIMPSON, WYOMING

MAX I. RICHTMAN, STAFF DIRECTOR
G. LAWRENCE ATKINS, MINORITY STAFF DIRECTOR

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

June 17, 1988

Sam Meade Cordes, Ph.D.
Professor and Head
Department of Agricultural Economics
University of Wyoming
Box 3354, University Station
Laramie, Wyoming 82071

Dear Dr. Cordes:

On behalf of myself and the other members of the Senate Special Committee on Aging, I would like to thank you for taking part in the June 13, 1988, hearing on the "Rural Health Care Challenge: Part 1: Rural Hospitals". Your excellent testimony broadened our understanding of the many problems facing rural hospitals and I believe it will enhance our efforts, as well as those of others active in this area who review the hearing record, to effectively address the pressing challenges facing hospitals in rural communities.

In addition to the questions I asked you at the hearing, I also would like to know what role you think the National Advisory Committee on Rural Health, of which you are a member, will play in efforts to make federal rural hospital policies more responsive. Please provide your answer in writing so that we may include it in the record.

We appreciate your taking the time to answer this question and will, of course, forward you the final hearing print as soon as it is available. Should you have any questions regarding this request, please contact Christopher Jennings or Jenny McCarthy of the Committee staff at (202) 224-5364.

Thank you for your cooperation and assistance with this request. We look forward to reviewing your response.

Best regards.

Sincerely,

John Melcher

Chairman

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UW
EXCELLENCE

College of Agriculture
The University of Wyoming
Sam M. Cordes, Head

Department of Agricultural Economics
PO Box 3354
Laramie, WY 82071
(307) 766-2386

June 30, 1988

The Honorable John Melcher
Chairman, Special Committee on Aging
U. S. Senate
Washington, D.C. 20510

Dear Senator Melcher:

Thank you for the opportunity to present testimony to your Committee, and for your kind letter of June 17. In your letter you asked me to indicate what role I believe the National Advisory Committee on Rural Health will play in efforts to make federal rural hospital policies more responsive.

Let me begin my answer by calling your attention to two items contained in the Committee's Charter. The first item points out that the Advisory Committee will work closely with the Office of Rural Health (ORH) and that one of the responsibilities of the ORH is "to coordinate rural health activities within the Department [of Health and Human Services], with particular attention to Health Care Financing Administration (HCFA) programs...[emphasis added]".

The second item notes that the function of the National Advisory Committee on Rural Health is to "...advise the Secretary concerning the provision and financing of health care services in rural areas." Because the Secretary has jurisdiction over HCFA, and because the Committee is to advise the Secretary, it would seem to me that the Committee is in an ideal position to make federal rural hospital policies more responsive--at least from the standpoint of financial responsiveness.

The exact steps the Committee could take to address your concern is a matter for speculation, given that the Committee's first meeting will not occur until mid-September. However, it would be my hope that federal rural hospital policies would be a very high priority for the Committee. I believe there is a need for a systematic analysis of federal hospital policies vis-a-vis rural hospitals, and I would hope the Committee would provide overall leadership and direction for such an analysis. My suspicion is that the rural-urban payment differential is but one of many federal policies that discriminate in a *de facto* fashion against rural hospitals. If my suspicion is correct, I would like to see all such discriminatory policies carefully identified and examined. I would then hope that the National Advisory Committee would use this information to push for both administrative and legislative remedies to correct the full-range of discriminatory policies and practices that may be facing rural hospitals.

In addition to taking a leadership role in correcting any inequities in *existing* federal policies, I would further hope that the Committee would also take a proactive approach to dealing with the rural hospital situation. It would seem to me that there may be a number of creative approaches and programs for assisting rural hospitals that go beyond our existing set of federal policies and programs. Again, the Committee could provide leadership in conceptualizing and proposing new and creative policies and approaches for insuring access to hospital and other health services in the most efficient manner possible.

Again, I appreciated the opportunity to testify before the Committee. It was encouraging to see so many Senators, including yourself, expressing so much concern and interest in the very real problems facing the rural health system. Thanks again for your leadership, and please let me know if I can be of service in the future.

Sincerely yours,

Sam Cordes
Professor and Head

SMC:ckk

cc: Jeff Human
Chris Jennings

Item 2

JOHN MELCHER, MONTANA, CHAIRMAN

JOHN GLENN, OHIO
LAWTON CHILES, FLORIDA
DAVID PRYOR, ARKANSAS
BILL BRADLEY, NEW JERSEY
QUENTIN N. BURDICK, NORTH DAKOTA
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JOHN HEINZ, PENNSYLVANIA
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DAVE DURENBERGER, MINNESOTA
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G. LAWRENCE ATKINS, MINORITY STAFF DIRECTOR

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

June 17, 1988

Michael E. Cooper
Administrator
Richland Parish Hospitals
P.O. Box 388
Rayville, Louisiana 71269

Dear Mr. Cooper:

On behalf of myself and the other members of the Senate Special Committee on Aging, I would like to thank you for taking part in the June 13, 1988, hearing on the "Rural Health Care Challenge: Part 1: Rural Hospitals". Your excellent testimony broadened our understanding of the many problems facing rural hospitals and I believe it will enhance our efforts, as well as those of others active in this area who review the hearing record, to effectively address the pressing challenges facing hospitals in rural communities.

Due to time constraints, Senators Grassley and Pressler were unable to ask a number of questions that we believe are important. Therefore, the Committee would very much appreciate your providing answers to the questions listed below so that we may complete the hearing record.

1. How are doctors, particularly obstetricians, who practice in rural communities affected by rising medical liability rates?
2. Do you feel that the Louisiana nursing home industry is supportive of the Medicare swing bed program?

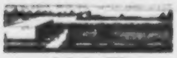
We appreciate your taking the time to answer these questions and will, of course, forward you the final hearing print as soon as it is available. Should you have any questions regarding this request, please contact Christopher Jennings or Jenny McCarthy of the Committee staff at (202) 224-5364.

Again, thanks for your cooperation. We look forward to reviewing your answers.

Best regards.

Sincerely,

John Melcher
Chairman



Richland Parish Hospitals

P. O. Box 388
Rayville, Louisiana 71269

507 Cincinnati
Delhi, Louisiana 71232

July 11, 1988

Honorable John Melcher
Chairman, Senate Special Committee on Aging
Senate Dirksen Office Building
Room G-41
Washington, DC 20520-6400

Dear Senator Melcher,

It has taken me some time to complete a study on the questions asked in your 17 June letter, as many of the people that I needed to talk to have been on vacation. I hope that my comments will reach you in time to be of some help.

1) How are doctors, particularly obstetricians, who practice in rural communities affected by rising medical liability rates ?

Louisiana is one of the few states in the nation that has adopted a $500,000 limit on liability. Due to this law, Louisiana has fared better than some states in the region. However, physicians of all types find increasing malpractice insurance premiums eating into their profit margins on an annual basis. I hope that Dr. McDonald's letter (attached) will speak to the specific issue as requested.

2) Do you feel that the Louisiana nursing home industry is supportive of the Medicare swing bed program ?

According to a Government Accounting Office briefing report presented to the House Select Committee on Aging in January, 1987, entitled "Post Hospital Care: Discharge Planners Report Increasing Difficulty in Placing Medicare Patients," 97 percent of hospital discharge planners had significant problems in placing Medicare patients in skilled nursing facilities (SNF). Some of the reasons most cited by both nursing homes and hospitals for not participating in Medicare SNF programs are: 1) Difficult and onerous compliance requirements; 2) Complex administrative and reporting burdens;, and 3) insufficient reimbursement.

In Louisiana, the shortage of SNF facilities is acute in most of the state including several metropolitan statistical areas. According to the Louisiana Medicare Fiscal Intermediary, there are currently 30 hospital distinct part and 34 swing bed SNF providers participating in the Medicare program. Twenty two (22) free standing SNF providers (nursing home) are certified for Medicare skilled services, with none of these facilities being within a 100 mile radius of our two hospitals. The preponderance of skilled level care is furnished by hospital based units: yet, both Medicaid and Medicare agencies believe that Louisiana is under-served As the swing bed program offers the most cost effective method for increased participation by hospitals in delivering skilled care, it should be expanded and more realistic levels of reimbursement for physicians be offered and HCFA should be encouraged by Congress to revise and uniformly implement SNF medical review criteria to eliminate physician and hospital uncertainty.

In summary, in view of the increased costs to nursing homes to meet Swing Bed criteria, and in light of the fact that hospitals have these costs "built in", the nursing home industry in Louisiana appears to be disinclined to offer skilled nursing services. Due to decreased utilization in small rural hospitals, it would appear that these hospitals would service as ideal bases for an expansion of Swing Bed skilled nursing services.

Thank you for allowing me to respond to these questions. Please feel free to call on me at any time in the future.

Sincerely yours,

Michael E. Cooper RD, NHA
Administrator

MEC/ab

enclosure

KENNETH E. McDONALD III, M.D. – A Professional Medical Corporation
PHONE 878-3737 506 BROADWAY DELHI, LOUISIANA 71232
DELHI CLINIC
Medical Service Group

June 27, 1988

Mr. Michael E. Cooper
Richland Parish Hospital
P. O. Box 388
Rayville, Louisiana 71269

Dear Mr. Cooper:

I would like to take a minute to answer your question regarding increasing malpractice premiums affect on OB practices of rural doctors. As you are aware, I have delivered babies in Delhi for the last 9½ years. I am presently 38 years old. Initially I had planned on practicing obstetrics in my family practice until the age of 45. However, inadvertently high malpractice premiums forced me to discontinue obstetrics on July 1 this year. Let me stress that the only reason I discontinued OB is because of the cost of malpractice insurance. I have noted a five fold increase in premiums over the last three to four years. Last year's premium was approximately $12,000-$13,000. This year would have been $20,000-$25,000. With 40-60 deliveries per year this makes OB prohibitive after one's time, effort and expenses are considered.

I was the last doctor in a 50-100 mile radius performing deliveries. Thirty to thirty-five of my patients were referred to a doctor in Monroe for their OB care. Also this doctor does not know how much longer he can afford to practice OB due to increasing malpractice cost.

Here in Delhi, OB's were charged $750 per normal delivery and $1,000 for C-Sections. In Monroe they will be charged $1,250 for a normal delivery and much more for a C-Section. Also hospital costs in Monroe will be much more expensive. It is also my feeling that the patients will not realize increasing quality of care with this increased cost as studies have shown that rural OB can be carried out with no difference in infant or maternal morbidity and mortality when compared to urban statistics.

It appears to me that some solution needs to be found. A doctor who delivers 50 babies per year pays the same premium as one who delivers 250 per year when he is only at one-fifth the risk. Also doctors in rural practice are less likely to face lawsuit. These factors and others should come into play when figuring one's malpractice premium.

Let me suggest the solution of determining the premium by the number of babies delivered. This could then be applied to their bill as an add on for insurance.

In summary, increasing malpractice costs are and have caused most rural doctors to discontinue obstetrics. In return for this, patients realize much higher cost for OB care with questionable if any increase in quality.

Sincerely,

Kenneth E. McDonald III

Kenneth E. McDonald, III., M.D.

KEMcDIIIMD/dg

Item 3

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

June 17, 1988

Jim Oliverson
Trustee
Montana Hospital Association
P.O. Box 5119
Helena, Montana 59604

Dear Jim:

On behalf of myself and the other members of the Senate Special Committee on Aging, I would like to thank you for taking part in the June 13, 1988, hearing on the "Rural Health Care Challenge: Part 1: Rural Hospitals". Your excellent testimony broadened our understanding of the many problems facing rural hospitals and I believe it will enhance our efforts, as well as those of others active in this area who review the hearing record, to effectively address the pressing challenges facing hospitals in rural communities.

Due to time constraints, Senator Grassley and I were unable to ask a number of questions that we believe are important. Therefore, the Committee would very much appreciate your providing answers to the questions listed below so that we may complete the hearing record.

1. What were the reasons you were forced to close the doors of the former facility you managed, Mission Valley Hospital?
2. How do you think frontier areas will receive the MAF idea?
3. How will quality health care in a MAF be assured?
4. What type of health care personnel will be used in the MAFs and how will they be utilized?
5. Do you think that the MAF concept could be an effective way to ensure access to acute and emergency care services in non-frontier rural areas?
6. Is the hospital you currently administer seeking participation in the MAF project?

Jim Oliverson
June 17, 1988
Page 2

7. How are doctors, particularly obstetricians, who practice in rural communities affected by rising medical liability rates?

I also would like to take this opportunity to, once again, congratulate the Montana Hospital Association in gaining preliminary approval by the Health Care Financing Administration of the MAF proposal. While I understand that certain questions remain on the specific terms upon which HCFA conditioned full approval of the proposal, I believe this development is certainly a step in the right direction. To help clarify this situation, I have included a number of questions about those terms in my letter to Dr. Ross Anthony of HCFA, who testified at the June 13 hearing. For your information, I am enclosing a copy of that letter.

We appreciate your taking the time to answer the enclosed questions and will, of course, forward you the final hearing print as soon as it is available. Should you have any questions regarding this request, please contact Christopher Jennings or Jennifer McCarthy of the Committee staff at (202) 224-5364.

Thank you for your cooperation and assistance with this request. We look forward to reviewing your responses.

Best regards.

Sincerely,

John Melcher
Chairman

Enclosure

cc: Jim Ahrens
Anthony Wellever

St. Luke Community Hospital & Nursing Home

July 6, 1988

John Melcher, Chairman
Special Committee on Aging
730 Hart Building
Washington D.C. 20510

Senator Melcher:

Thank you for your letter of June 17, 1988 in which you asked me seven questions about my perceptions of health care and MAF's.

#1 What were the reasons you were forced to close the doors of the former facility you managed, Mission Valley Hospital?

The reasons are numerous and the causes are interrelated. The Hill-Burton program build too many hospitals (as you know 600,000 beds were built which doubled the nation's bed supply in a matter of approximately 20 years). The beds were then filled through 1965 legislation which created Medicare and Medicaid. The professional bureaucrats soon realized that the system could not continue to fund the growing needs of the industry. They also realized that many of those hospitals were nearing 20 to 25 years of age and at that point would have to be replaced or improved. Therefore, most if not all low interest funds for hospitals were slashed or discontinued and in their place, new costly life-safety codes and more stringent Conditions of Participation were planned and published. Financial encouragement for nursing schools were significantly reduced and medical schools were thrown into a panic by the sudden discovery of a physician glut. Publicity was also generated to condition the public to the notion that "bigger is better" . . bigger therefore is also safer, more advanced, more efficient, and better equipped.

The final move was to create a payment system which would reward the large and penalize the small, obviously that was not the stated intent of the law, but not a single hospital administrator in my area had any doubt that the system would eventually favor "the big guys" and/or heavily populated states.

You now have most of the major ingredients in a generic sense of small town hospital USA. To complete this recipe for failure, you need to add some of the local St. Ignatius color. Most small town doctors work very hard, long hours, have little relief, and receive less pay than their urban counterparts. One of my physicians was sued by a client (who by the way came back to the same physician to have her next child delivered). The doctor lost the malpractice case and was devastated. Then the physician partner left the practice and as a result, the remaining physician at one time was on-call for a period in excess of 45 days. Attempts were made to get a replacement. We were not successful and eventually, the last physician left. I was able to hire physicians for a short time, but the cost was very high and the continuity of care was certainly compromised.

St. Ignatius as you know, is on a reservation and therefore, with the recent decision by Public Health to go to a DRG reimbursement basis, 75% of my reimbursement is fixed, in that I have no control over it. When we were notified that Public Health Service would be going to a DRG basis of payment, we clearly saw the handwriting on the wall or the grim reaper sta standing at our door. One of the things that hurt us most deeply, was the DRG reimbursement for laboratory services. Much of our PHS activity is conducted on an outpatient basis and HCFA's method of determining payment for laboratory services, we felt was extremely unfair. Unfair, because when the rate was set for laboratory fees in the State of Montana, the basis of the rate determination was established by surveying private laboratories in large communities throughout the state. It is my understanding, that not a single hospital laboratory was included in the HCFA survey. The larger independent labs are not open 24 hours a day, are not subject to the stiff quality control and personnel qualification licensure standards that govern hospitals. They have a much larger volume than the average hospital in the state and more expensive equipment which turns out multiple tests much less expensively than the average hospital.

When PHS announced their intention to begin reimbursing us on the basis of DRGs, we knew our days were numbered. We had already anticipated a loss for the year of some $40,000 and we knew that the additional loss would push us over $150,000 loss for the year. We realized we could not continue operating and incurring financial obligations that we would be unable to meet.

Recruiting nurses was also becoming difficult and would have become nearly impossible within the next 12 - 18 months even if the hospital had continued operation.

Increasing malpractice rates have also contributed heavily to the physician's reluctance to continue practicing in a rural setting. Obstetrics is receiving a lot of consideration currently but, malpractice for surgery, orthopedics, and emergency room are also sharply escalating and thereby threatening the ability of the rural practitioner to continue his or her practice.

As I mentioned earlier, "Nearly 75% of my reimbursement is on the DRG basis" . . . not only does that mean that I have no control of my income, but it also says that the individual seeking the care is not paying the bill, therefore they want the best, therefore they seek out the specialists in the larger city areas. The people have voted with their feet. The day of the John Wayne hospital is over.

In summary, the reasons for my hospital's failure, were the inability to attract and retain physicians, a failing rural economy, declining patient utilization, high malpractice insurance, inequitable reimbursement, patients leaving town (a recent study by the University of Washington School of Medicine concluded that 40 to 60 percent of the patients are leaving rural america and going to the larger hospitals in metropolitan areas. The study also noted that only 15 to 20 percent of the visits are medically necessary), and finally exhaustion and isolation of community health leaders.

#2 How do you think frontier areas will receive the MAF idea?

I believe the reception of the MAF will be one of enthusiastic support. Most of us in rural america are realists and therefore we don't expect to have Mayo Clinic West in our backyard. But we do believe that we have earned the right to access healthcare at some level which will prevent death and reduce longterm injuries. I believe that MAF will fill this need.

#3 How will quality healthcare in a MAF be assured?

The quality of the care given in a MAF will be assured by the criteria for licensure which has been established by the State Department of Health and the Montana Hospital Association in cooperation with representatives from many small rural hospitals. I personally have been impressed in the seventeen years that I have served as a small hospital administrator by the sensibility, practicality, and cooperation of the Department of Health. They understand their job and they do it well.

#4 What type of healthcare personnel will be used in the MAFs and how will they be utilized?

Understandably we will use nurses, RNs, LPNs, and aides. We also plan to use physical therapists, respiratory therapists, dietary consultants, lab personnel, x-ray personnel. We feel very strongly about not compromising the quality of care that will be made available to the people who qualify for the MAF. We envision these allied health personnel as physician extenders or multipliers. Again, based on my experience of more than fifteen years in a rural setting, the high majority of our hospital staffs are very creative, resourceful individuals who in addition to their acute sense of dedication to their community, also realize their limitations. When those limitations become obvious, I have never observed a reluctance to transfer the patient immediately to a high level of care.

#5 Do you think that the MAF concept could be an effective way to insure access to acute and emergency care services in nonfrontier rural areas?

Yes, I do. There may have to be some unique tailoring of the concept to fit in with the particular needs of a specific area's economy, climate, or ethnic background.

#6 Is the hospital you currently administer currently seeking participation in the MAF project?

No.

#7 How are doctors, particularly obstetricians who practice in rural communities affected by rising liability rates?

My immediate response to the question is the fact that currently one third of the counties in Montana have no obstetrical services. I am informed that in the 90 day period between January 1, 1989 and April 1 1989, the number of physicians who will be discontinuing the provision of obstetrical services will raise that figure to two thirds, that is two thirds of the counties in Montana will no longer have obstetrical services. I personally know of several physicians who have quit not only because of the high yearly malpractice rates, but also because of the malpractice "tails". One of my physicians in Ronan discontinued cbstetrics after nearly twenty years because his reimbursement of $238.00 per delivery from Medicaid would not come close to equaling his cost of malpractice insurance.

I know of many physicians who are currently exploring options other than private practice, such as HMOs, working for the VA, PHS, and other governmental agencies so they won't have to worry about the cost of malpractice and the tail. The complication of malpractice go far beyond the actual cost and the pain and humiliation of the suit. Recently one of my physicians explained to me that his insurance company had informed him since he was no longer paying an obstetrical malpractice premium, they would not cover him if he delivered a baby except in an emergency situation. He understandably queried the insurance company, asking them to define the emergency situation and he asked that they put that definition in writing. Many months have gone by and as you might guess, the insurance company has not supplied the definition of an emergency OB. The physician reminded me that the insurance company went on to tell him that if he did deliver a child and a malpractice suit was brought as a result of that delivery, the physician's personal assets and not the insurance company would be at risk.

The physician explained his current dilemma. If he was on emergency room call and a patient in labor presented herself at the emergency room and he did not see the patient but instead referred her to Kalispell or Missoula since he no longer practiced OB . . . he would be sued for abandonment if (A he did not see the patient in the ER and (B if he did and the patient delivered the child while in route to the larger hospital. The second scenario involves a similar situation where he is on ER call and the patient in labor presents herself. He then makes the determination that this patient does not have enough time to be transferred to Missoula or Kalispell, therefore he delivers the patient, but rather than deivering in 3/4 of an hour, the woman delivers in an hour and a half (which would have been enough time for her to get to Missoula or Kalispell). If there was a problem in the delivery, the physician's personal assets would be at risk. He shared with me one example of a patient who sued the estate of the deceased physician's wife. Allegedly, the patient collected a large sum from the former physician's estate (wife) and left her nearly penniless and literally scrubbing floors for a living.

I would like to thank you Senator, once again, for your concern and attention. Your concern, and the thoroughness of your staff especially Jennie McCarthy who worked most closely with me are very encouraging. Thank you Senator, if I can be personally of any assistance to you or your staff at any time in the future, please don't hesitate to call me. I also deeply appreciate receiving a copy of your letter to Dr. Ross Anthony. If there would be an opportunity for you to share his answers with me, I would appreciate that also. Thank you again for your help.

With deepest personal appreciation.

Cordially,

James T. Oliverson
Administrator

JTO/pr

cc: Jim Ahrens
Tony Wellever

Item 4

JOHN MELCHER, MONTANA, CHAIRMAN

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

June 17, 1988

J. Patrick Hart
Director
Office of Rural Health Services
University of North Dakota
501 Columbia Road
Grand Forks, North Dakota 58201

Dear Mr. Hart:

On behalf of myself and the other members of the Senate Special Committee on Aging, I would like to thank you for taking part in the June 13, 1988, hearing on the "Rural Health Care Challenge: Part 1: Rural Hospitals". Your excellent testimony broadened our understanding of the many problems facing rural hospitals and I believe it will enhance our efforts, as well as those of others active in this area who review the hearing record, to effectively address the pressing challenges facing hospitals in rural communities.

Due to time constraints, Senator Pressler and I were unable to ask a number of questions that we believe are important. Therefore, the Committee would very much appreciate your providing answers to the questions listed below so that we may complete the hearing record.

1. How are the residents in the communities that are participating in the Affordable Rural Coalition for Health (ARCH) project responding to it?
2. How widely applicable do you think the ARCH approach could be to other rural areas of the nation?
3. Based on your experience with the ARCH project, can you give us any idea about what reactions to expect on the part of rural communities to the "Medical Assistance Facility" proposal?

In response to your inquiry about the Department of Health and Human Services' report to Congress on the Studies of Urban-Rural and Related Geographical Adjustments in the Medicare Prospective Payment System, I am enclosing a copy of this report for your review. Although it was provided to the House and Senate authorizing committees in late December of last year, it was only very recently made available to this committee. In addition, I would like to share with you a copy of a recent ProPAC report which was sent to me soon after the hearing.

We appreciate your taking the time to answer the enclosed questions and will, of course, forward you the final hearing print as soon as it is available. Should you have any questions regarding this request, please contact Christopher Jennings or Jennifer McCarthy of the Committee staff at (202) 224-5364.

Best regards.

Sincerely,

John Melcher
Chairman

Enclosures

RESPONSE TO QUESTIONS FROM
SENATORS MELCHER AND PRESSLER

1. How are the residents in the communities that are participating in the Affordable Rural Coalition for Health (ARCH) project responding to it?

The response has been quite favorable. Community leaders have contributed their time to serving on the local ARCH boards. There also has been a generally favorable response by residents who attended presentations on ARCH that were made at meetings of local civil clubs. The local radio stations and newspapers have been extremely cooperative in carrying stories about what the ARCH projects are seeking to accomplish and about the progress of the local projects. Another indication of a favorable response is the ability of the local ARCH boards to raise local funds to match the Kellogg Foundation grants. I believe that a favorable response can be obtained through extensive education of community residents about the conditions and problems of the local health system and the opportunity for voicing their opinions through surveys, focus groups, and discussion at meetings of civic clubs.

2. How widely applicable do you think the ARCH approach could be to other rural areas of the nation?

Our project sites are located in the upper Midwest; in Colorado, Montana, and North Dakota. I believe that the ARCH approach is definitely applicable to other midwest and western states and most likely applicable to other areas of the country as well. The principles of involving community residents in determining how the community health system will meet their needs and of shouldering their share of the responsibility for obtaining resources to make necessary changes in the health system will fit well with the values of most rural areas in our nation. Another reason that I believe that the ARCH approach will work in other rural areas of the nation is that we have received a considerable number of requests for information about ARCH from hospitals in other parts of the country. In discussing the problems that these hospitals are facing we have found that the problems and community conditions are similar to those faced in our ARCH communities. Finally, I believe that be including two kinds of sites, consortium and single sites, we have provided opportunity to find out how to address problems in two major kinds of rural settings.

3. Based on your experience with the ARCH projects, can you give us any idea about what reactions to expect on the part of rural communities to the "Medical Assistance Facility" proposal.

As I understand it, the Medical Assistance Facility (MAF) proposal creates a new category of facility licensure that would involve a resizing or downsizing of the local hospital. It will be quite important to present the proposal to rural communities in a positive light that emphasizes the range of services that will be provided through a MAF and the quality of the services that are provided. This will be necessary to offset the initial reaction of many residents that they are "losing the hospital." I believe that our experience with the ARCH project indicates that the initial idea of losing or closing the hospital can be addressed reasonably well by educating and involving local leaders and the wider community in the need for and process of making a transition. It is important also to understand that even with education there will likely be a feeling of loss of a valued part of a community's history and identity and that a part of the transition process must often include direct attention to the emotions that accompany such a loss. That is, our experience indicates that restructuring a local health system is in part a technical problem and in part a social-emotional problem. Both parts must be addressed.

I would also like to point out that the MAF concept is applicable and needed in two distinct situation. One is the situation of the frontier or largely isolated hospital and the other is the situation in which there is a cluster of rural hospitals in relatively close proximity. There is likely to be a subtle, but important distinction in the reaction of rural residents in these two situations.

In the first situation, that of a frontier or isolated community, the residents may in fact, by virtue of downsizing the scope of services, lose access to certain services, percieve themselves as becoming more isolated with regard to health services, and be required to adapt to new patterns of utilization involving fairly distant regional referral centers. In the second situation these rural hospitals may be relatively close to one another and make up a regional cluster. Two of them may need to downsize or transition into a MAF while the third maintains or expands its services as part of a regionalization of rural services. In this case the rural residents served by the two hospitals that convert to a MAF may lose immediate access to certain services but have those services relatively near, perceive themselves as having lost their services (or hospital) to another community, and need to adapt to a new pattern of utilization involving a community that quite likely has been perceived in a competitive light in the past. The approach to implementing the MAF concept in both situations will need to be similar in emphasizing the economic realities and advantages, maintenance of quality emergency and primary care, and availability of adequate transportation. The second situation will require, however, additional attention to the problems of integrating the communities into a regional health system. There will be a need to build a regional coalition among healthcare providers and to direct community education and healthcare marketing efforts toward helping the rural residents to change from a local to a regional orientation to health service utilization. Our experience thus far with the consortium sites in the ARCH project suggests that regional collaboration among the hospitals and the development of a regional identity among residents are proceeding in the sites. The process of bringing about a regional orientation, however, has required a great deal of community organizing effort which I believe would be the case also in implementing the MAF concept among a cluster of rural hospitals.

Item 5

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

June 17, 1988

Timothy Karl Size
Executive Director
Rural Wisconsin Hospital Cooperative
404 Phillips Boulevard
Sauk City, Wisconsin 53583

Dear Mr. Size:

On behalf of myself and the other members of the Senate Special Committee on Aging, I would like to thank you for taking part in the June 13, 1988, hearing on the "Rural Health Care Challenge: Part 1: Rural Hospitals". Your excellent testimony broadened our understanding of the many problems facing rural hospitals and I believe it will enhance our efforts, as well as those of others active in this area who review the hearing record, to effectively address the pressing challenges facing hospitals in rural communities.

Due to time constraints, Senator Grassley and I were unable to ask a number of questions that we believe are important. Therefore, the Committee would very much appreciate your providing answers to the questions listed below so that we may complete the hearing record.

1. Has the National Rural Health Association elected to challenge the legal basis of the Medicare urban-rural differential? If so, what is the status of this challenge?

2. As you know, a common misconception is that the quality of medical care provided in rural hospitals may not be on a par with that of urban hospitals. While I would take issue with this misconception, I think you would agree that quality assurance must be a top priority with rural hospitals.

    i) Do you think there are differences on the whole between the quality of care provided in rural and urban hospitals?

    ii) What quality assurance measures have you developed or planned to develop for hospitals in the cooperative?

In response to your inquiry about the Department of Health and Human Services' report to Congress on the Studies of Urban-Rural and Related Geographical Adjustments in the Medicare Prospective Payment System, I am enclosing a copy of this report for your review. Although it was provided to the House and Senate authorizing committees in late December of last year, it was only very recently made available to this committee. In addition, I would like to share with you a copy of a recent ProPAC report which was sent to me soon after the hearing.

We appreciate your taking the time to answer the enclosed questions and will, of course, forward you the final hearing print as soon as it is available. Should you have any questions regarding this request, please contact Christopher Jennings or Jennifer McCarthy of the Committee staff at (202) 224-5364.

Best regards.

Sincerely,

John Melcher

Chairman

Enclosures

Rural Wisconsin
Hospital Cooperative

July 8th, 1988

Senator John Melcher, Chairman
Special Committee on Aging
Washington, DC 20510-6400

Dear Senator Melcher:

Thank you for your kind letter of June 17th and the copy of the Department of Health and Human Service's report to Congress on the "urban-rural adjustments."

The following is a brief reply to the additional questions you wanted to complete the hearing record.

1. "Has the National Rural Health Association (NRHA) elected to challenge the legal basis of the Medicare urban-rural differential? If so, what is the status of this challenge?"

   At the May meeting of the NRHA Board, the Board authorized the filing of a law suit against the Health Care Financing Administration (HCFA) to challenge the constitutionality of its implementation of the Prospective Payment system. We will be filing a brief in a District Court early this Fall.

   Our position is that while Congress established separated rural and urban rates it did not require HCFA to administer the Program in such an unreasonable and discriminatory manner. We see our effort as a supplement to, not a replacement for, the necessary efforts of your and other Congressional Committees.

   We have successfully initiated a national fund drive to finance this legal and educational effort but recognize that this will be an ongoing effort over the next couple of years. While our primary contributors are obviously rural hospitals, we have also received funds from a wide variety of local, regional and national companies and organizations.

2. "As you know, a common misconception is that the quality of medical care provided in rural hospitals may not be a par with that of urban hospitals. While I would take issue with this misconception, I think you would agree that quality assurance must be a top priority with rural hospitals."

   i) "Do you think there are differences on the whole between the quality of care provided in rural and urban hospitals?"

      In a few words, I doubt it, but I believe you have correctly identified one of the critical challenges to be faced by all hospitals over the next several years - rural and urban alike. The exact answer to your question depends on the general acceptance of comparative evaluation techniques that I do not believe yet exists. However it is clear that we soon will arrive at a time when a concensus of what constitutes fair indicators of quality will naturally or forcefully occur.

I noted the following in my written testimony: "The Joint Commission on Accreditation of Hospitals (JCAH), private and government sectors are all shifting their focus to 'did you make use of your capabilities and did you get good outcomes as the result of your actions?' (O'Leary, JCAH) According to the firm of Price Waterhouse, '...rural residents have demonstrated their willingness to drive to the city if they do not have confidence in local doctors.' "

I believe that the preconceptions "that the quality of medical care provided in rural hospitals may not be a par with that of urban hospitals" is a direct consequence of the widely believed technological imperative that bigger and more specialized is always better. We need to replace this imperative with another, that different settings are best suited for different tasks and roles.

One can theorize and generalize about how bad basic health care is in a large urban hospital as easily as one can theorize about small rural hospitals sponsoring specialty care beyond its scope.

ii) "What quality assurance measures have you developed or planned to develop for hospitals in the Cooperative?"

In my mind, this question gets to the heart of the matter, all hospitals are entering a new era of outcome oriented quality assurance with substantially greater public accountability.

How can rural hospitals best handle this new challenge? Will models be developed that are applicable to and affordable by rural hospitals? How can rural hospitals best manage the review problems inherent with relatively small numbers of the local medical staff and medical activity? Can we develop quality review processes that are not implicitly biased by the technological imperative that bigger and more specialized care is always better?

For exactly this purpose, the Cooperative has been awarded a grant of $341,000 for two years from the Robert Wood Johnson Foundation, the nation's largest health care philanthropy (with renewal expected for a like sum for 2 more years).

Throughout this year and the next three we will be working to improve Cooperative hospitals' quality of care through (1) administrative and technical support for existing hospital quality assurance programs, (2) the implementation of a cooperative quality assurance program and physician credentialling process.

We very much appreciate your leadership and initiative in emphasizing the importance of rural health and hospitals through the two hearings you are holding this summer. Again, thanks for inviting our participation.

Sincerely,

Tim Size
Executive Director

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Item 6

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

June 20, 1988

C. Ross Anthony, Ph.D.
Associate Administrator for Program Development
Health Care Financing Administration
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Anthony:

On behalf of myself and the other members of the Senate Special Committee on Aging, I would like to thank you for participating in the June 13 hearing on the "Rural Health Care Challenge: Part 1: Rural Hospitals". We appreciated receiving your excellent testimony on the policies of the Health Care Financing Administration concerning rural hospital reimbursement and related issues of mutual concern.

Due to time constraints, Senators Burdick, Grassley, and I were unable to ask a number of questions that we believe are necessary for completing the hearing record. Therefore, we would very much appreciate your providing timely written responses to the questions listed below.

1. Recently, HCFA simulated the impact of OBRA '86 and OBRA '87 changes on Medicare payments to rural hospitals. Please provide a table comparing data on operating margins from the third year of prospective payment (PPS) with those projected under OBRA '86 and OBRA '87.

2. A major concern of rural hospitals has been and continues to be the statutory requirement that HCFA maintain separate urban and rural standardized payment amounts.

   a) What is the existing difference in urban and rural hospital costs? How has this difference changed over time? (If possible, please include in your answer a break down of rural vs. urban hospital costs according to size (e.g., under 50 beds, 59-99 beds, etc.), sole community provider status or other class designation, and year.)

   b) What does the available research, both sponsored by HCFA or with which you are familiar, tell us about the reasons for these differences? In particular, to what extent do the differences in costs reflect differences in severity of illness of patients that are unrecognized by DRG case mix and differences in the nature of quality of care rendered by comparable urban and rural hospitals?

   c) Do the research findings on the subject of the differential justify a continuation of different urban and rural standardized payment amounts?

   d) HCFA's report of December 24, 1987, entitled Studies of Urban-Rural and Related Geographical Adjustments in the Medicare Prospective Payment System, argues that an ideal PPS payment system would base reimbursement on the efficient cost of treating Medicare patients. In the absence of data showing that the higher costs of urban hospitals are indeed warranted, do you still think the Congress should continue the urban-rural differential?

   e) What research projects has HCFA sponsored to examine these cost differentials? When can we expect their findings?

   f) What would it cost to eliminate the Medicare urban-rural reimbursement differential?

3. As you know, the Area Wage Index takes into consideration a relatively circumscribed area in determining wages for both professional and non-professional health care personnel. While it may be reasonable to calculate non-professional staff wages based on local wages, professional wages may be affected by more than the local labor market. For example, rural hospitals in areas that have a shortage of psychologists, physical therapists, and nurses must compete with their urban counterparts for these professionals. With respect to nurses, some hospitals with severe shortages in this field see no other choice but to compete on an international market. Nevertheless and despite ProPac's recommendations to the contrary, HCFA pays all rural hospitals, whether they are close to or distant from urban areas, as if they faced the same wage index.

   a) Why has HCFA chosen not to follow ProPac's recommendations concerning reforms of the Area Wage Index?

   b) What research findings support HCFA's rural wage index policy?

   c) Does HCFA have any plans to establish a more rational wage index policy?

4. Are further changes in PPS needed to protect rural hospitals?

5. Sole community hospitals (SCH) appear to be poorly protected under current HCFA policies. For example, the special payment rate offered SCH facilities is often lower than their PPS payment rate. Thus, the designation of SCH may offer eligible facilities with little or no additional financial protection, and it appears to serve little more than a "hold harmless" function.

   a) What additional financial protection should be offered for SCH facilities?

   b) Even with the changes proposed in HCFA's criteria for determining if a hospital qualifies for "volume protection", the process of obtaining this protection would be too lengthy. It might take as long as a year to actually receive higher payments. In view of the fragile financial position of many of these hospitals, even 6 months may be too long. Would HCFA be willing to explore a more expeditious interim payment plan following initial review and approval of a hospital's application by a regional office?

   c) Many rural hospitals believe the criteria for "volume protection" are too vague. Further, they have little information on how much additional money such "volume protection" payments will provide them. Please outline several sample cases using different criteria, the threshold HCFA would employ with the stated criteria, and the adjustments that would be made.

   d) Is HCFA providing SCH facilities with any technical and/or administrative assistance to help them improve their financial condition?

6. A major issue facing Medicare beneficiaries who live in rural communities whose hospital has closed is access to acute care services. Has HCFA studied the impact of a hospital closure on beneficiary access in any such communities? If not, does HCFA intend to fund such studies in the near future?

7. As you know, the Conference Report for the Medicare Catastrophic Coverage Act further elaborated on the 10 percent set-aside for health care research in rural areas. What progress has HCFA made with respect to the rural health care research program?

8. What steps, if any, is HCFA taking to promote the formation of hospital cooperatives or other innovative arrangements designed to strengthen rural hospitals and help ensure health care access in rural areas?

9. At the hearing, you announced that HCFA provided preliminary approval of the proposal of the Montana Hospital Research and Education Foundation to establish a "Medical Assistance Facility" in certain frontier communities in Montana. More specifically, full approval of the proposal was made conditional upon completion of a feasibility study, for which HFCA provided the Foundation $100,000 to carry out, and making certain changes to the proposal. In addition, approval of the Medicare/Medicaid waivers was deferred for a year.

   a) If the Foundation is able to comply with the changes HCFA outlined as needed before a year has passed, would HCFA be willing to grant the requested Medicare/Medicaid waivers at that time?

   b) Is it correct to assume that if the Foundation meets all of HCFA's requirements and that the proposal therefore is fully approved, the $100,000 provided for the feasibility study will not be taken from the $440,109 budget needed to adequately fund the proposal?

We appreciate your taking the time to answer these questions and will, of course, forward you the final hearing print as soon as it is available. Should you have any questions regarding this request, please contact Christopher Jennings or Jenny McCarthy of the Committee staff at 224-5364.

Thank you for your cooperation and assistance with this request. We look forward to reviewing your responses.

Sincerely,

John Melcher

Chairman

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of the Secretary
Washington, D.C. 20201

AUG 12 1988

The Honorable John Melcher
Chairman, Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman,

Enclosed are responses to your questions and those of Senators Burdick and Grassley following the June 13 hearing on rural hospitals.

I hope that this provides you with the necessary information to complete the hearing record. If I can be of additional assistance, please me know.

Sincerely,

Trisha

Patricia Knight
Deputy Assistant Secretary
for Legislation (Health)

Enclosure

Copy to: Senator Charles Grassley
Senator Quentin Burdick

Questions Regarding Rural Hospitals

1. Recently, HCFA simulated the impact of OBRA 86 and OBRA 87 changes on Medicare payments to rural hospitals. Please provide a table comparing data on operating margins from the third year of prospective payment (PPS) with those projected under OBRA 86 and OBRA 87.

A. The table below presents actual Medicare operating margins (PPS operating payments minus operating costs divided by PPS operating payments) for the third year and compares them with simulated margins based on payment rules that apply in FY 1988 and FY 1989. The simulations were structured so that the overall margin in the simulations was held constant at the PPS-3 level; that is, an average of 9 percent. Different simulation methods, of course, generate different estimates.

	Number of Hospitals	Actual PPS 3 Margins FFY 86	OBRA 86,87 100% Federal FFY 1988	OBRA 87 100% Federal FFY 1989
National	3,685	9.0%	9.0%	9.0%
Urban	1,866	10.0	8.8 - 9.5	8.6 - 9.2
Rural	1,819	3.0	7.5 - 9.6	8.8 - 10.8

2. A major concern of rural hospitals has been and continues to be the statutory requirement that HCFA maintain separate urban and rural standardized payment amounts.

2a. What is the existing difference in urban and rural hospital costs? How has this difference changed over time? (If possible, please include in your answer a break down of rural vs. urban hospital costs according to size (e.g. under 50 beds, 50-99 beds, etc.,) sole community provider status or other class designation, and year).

A. Based on cost report data from the third year of PPS, we estimate that Medicare operating costs per discharge for rural hospitals are approximately 60 percent of Medicare operating costs per discharge for urban hospitals. For the first year of PPS, the corresponding estimate is about 61 percent.

This finding is generally consistent with results from the National Center for Health Services Research (NCHSR). They studied American Hospital Association data from 1981-1985 and found that the rural-urban cost differential in total costs per discharge had remained almost constant. A discharge from a rural hospital costs 59 percent as much as a discharge from an urban hospital in 1981 and again in 1985.

The relative stability in the rural-urban cost differential implies that rural and urban hospital costs rose at about the same rate over this period with a slight difference: Medicare operating costs per discharge rose slightly faster for urban hospitals than for rural hospitals over the three PPS years. Urban hospitals' rate of increase is estimated to be 20 to 21 percent, compared with rural hospitals' 18 to 19 percent. These rates of increase vary little by hospital size. Sole community hospitals experienced a lower rate of increase than other rural hospitals (an approximately 13 percent increase over the three PPS years).

2b. What does the available research, both sponsored by HCFA or with which you are familiar, tell us about the reasons for these differences? In particular, to what extent do the differences in costs reflect differences in severity of illness of patients that are unrecognized by DRG differences in the nature of quality of care rendered by comparable urban and rural hospitals?

A. The available research suggests that in many DRGs, smaller hospitals (both rural and urban) generally provide less intensive care for most patients. The research also suggests that physicians in urban hospitals practice a more technology-intensive style of care that cannot be explained by DRG case mix or severity of illness. There is a strong correlation between procedure intensity and the size of the hospital, and between procedure intensity and teaching activities. Physicians in large, teaching hospitals simply do more to diagnose and treat patients, an orientation likely fostered by a densely concentrated population able to support a wide range of services.

2c. Do the research findings on the subject of the differential justify a continuation of different urban and rural standardized payment amounts?

A. Yes. As cited above, our research and that of NCHSR have both found a discharge from a rural hospital costs about 60 percent as much as a discharge from urban hospitals from 1981 to 1985. The fact that urban hospitals have had consistently higher costs argues for keeping a differential between rates paid to urban and rural hospitals. To do otherwise (i.e., paying both urban and rural hospitals the same rate without any new adjustments), would grossly underpay urban hospitals and grossly overpay rural hospitals.

2d. HCFA's report of December 24, 1987, entitled Studies of Urban-Rural and Related Geographical Adjustments in the Medicare Prospective Payment System, argues that an ideal PPS payment system would base reimbursement on the efficient cost of treating Medicare patients. In the absence of data showing that the higher costs of urban hospitals are indeed warranted, do you still think the Congress should continue the urban-rural differential?

A. Yes. The higher costs of urban hospitals are due to a number of factors, including urban physicians practicing a more intensive style of medicine. Simply because efficient costs are unknown, it is premature to conclude that the higher costs of urban hospitals are unwarranted. In addition, since rural costs are significantly less than urban costs, it would be inappropriate for Medicare to pay rural hospitals at the same rate as urban hospitals. Such a policy would result in windfall payments to rural hospitals.

2e. What research projects has HCFA sponsored to examine these cost differentials? When can we expect their findings?

A. HCFA sponsored a major research project on differences in rural and urban hospital costs for the Report to Congress, Studies of Urban-Rural and Related Geographical Adjustments in the Medicare Prospective Payment System. This research, conducted by the Center for Health Economics Research (CHER), is also the subject of a full-length article in Medical Care, a journal published by the American Public Health Association. Further HCFA-sponsored research by CHER on the effects of volume declines on rural hospital costs is on-going and is expected to be completed by Fall 1989.

2f. What would it cost to eliminate the Medicare urban-rural reimbursement differential?

A. If the urban-rural reimbursement differential were to be eliminated, we would strongly advocate that it be accomplished in a manner that would be budget neutral to current outlays for PPS. The intent of eliminating the differential should be to do away with arbitrary geographic distinctions as a major determinant of payment. Ending the distinction should not be undertaken without careful consideration, though, since the costs of providing inpatient care vary across the country along many dimensions, some of which we adjust for already and others which we are still attempting to determine. Any changes should be redistributive, to make PPS more, not less, equitable.

Eliminating the urban-rural differential should not be adopted simply to pay rural hospitals at the urban rate -- their costs have been demonstrated to be lower, so such a tack would yield costly and unnecessary windfalls. Neither should urban hospitals simply be paid at the rural rate, or at some average of the two, without other essential adjustments to PPS to make it more, not less, equitable.

3. As you know, the Area Wage Index takes into consideration a relatively circumscribed area in determining wages for both professional and non-professional health care personnel. While it may be reasonable to calculate non-professional staff wages based on local wages, professional wages may be affected by more than the local labor market. For example, rural hospitals in areas that have a shortage of psychologists, physical therapists, and nurses must compete with their urban counterparts for these professionals. With respect to nurses, some hospitals with severe shortages in this field see no other choice but to compete on an international market. Nevertheless and despite ProPAC's recommendations to the contrary, HCFA pays all rural hospitals, whether they are close to or distant from urban areas, as if they faced the same wage index.

3a. Why has HCFA chosen not to follow ProPAC's recommendations concerning reforms of the Area Wage Index?

A. In its March report, ProPAC recommended that labor market areas for determining wage values be improved. ProPAC recommended that urban area markets be subdivided into Census Bureau defined urbanized and non-urbanized areas, and that rural areas be subdivided into "urbanized" areas -- counties with a city having a population of at least 25,000 -- and "non-urbanized" areas. We did not accept ProPAC's recommendation for several reasons:

o Since the Census Bureaus's definition of urbanized area is based on population density and is defined to the census tract level, urbanized area boundaries do not coincide with street addresses, zip codes or other identifiers on which hospitals, intermediaries, and HCFA base their data.

- The actual boundaries of urbanized areas are volatile and subject to dramatic change when extensive development occurs. However, the Census Bureau routinely draws boundaries of urbanized areas only once each decade following the decennial census. Hence, we would expect many cases to arise between census years in which hospitals would argue that their locations should be reclassified as urban.

- Finally, it is not clear that ProPAC's refinements more closely reflect the markets in which hospitals compete for labor. While ProPAC's refinements would more closely capture wage differentials, in fact the greatest explanatory power would be achieved through a hospital-specific wage index. Such an index, however, would not be in accordance with the basic tenets of the Medicare prospective payment system.

We understand ProPAC intends to advise us in its comments on the proposed FY 1989 prospective payment regulations and rates as to how the accurate designation of urbanized areas can be accomplished. We will examine ProPAC's comments carefully in this regard.

3b. What research findings support HCFA's rural wage index policy?

A. HCFA has sponsored studies of the rural wage index to examine:

- separate wage indexes for rural counties that are adjacent to Metropolitan Statistical Areas (MSAs), and

- alternative rural labor market areas that have been defined by the Bureau of Economic Analysis (BEA).

The studies have found that neither alternative is clearly preferable to the current system; using separate wage indexes for counties adjacent to MSAs would disadvantage rural hospitals in counties not adjacent to MSAs and using BEA defined areas does not significantly change the impact of the wage index. Our research indicates that the current wage index is not a source of major payment inequities for rural hospitals.

3c. Does HCFA have any plans to establish a more rational wage index policy?

A. HCFA's wage index policy has been refined since the inception of the prospective payment system. In the proposed rule published May 27, 1988, we propose to base the wage index solely on 1984 wage data (rather than a blend of 1982 and 1984 data) although we are not proposing to change the methodology for computing the wage index. HCFA is presently examining the wage index for adjustments to account for differences in occupational mix, which was required by OBRA-87. Additionally, OBRA-87 requires that we update the wage index not later than October 1, 1990, and every three years thereafter. However as previously mentioned, our research, which is discussed in our report to Congress on the urban/rural differential, concludes that the current wage index is not a source of significant payment distortions.

4. Are further changes in PPS needed to protect rural hospitals?

A. We have conducted simulations of the impact of OBRA 86 and OBRA 87, as cited above, and found that rural hospitals should achieve parity with urban hospitals in FY 1988, both in terms of average margins and in terms of the likelihood of earning positive Medicare operating margins. Despite this fact, there are concerns about sole community hospitals (SCHs) which stem from research findings indicating that SCHs face special circumstances. The answer to the following question addresses our concerns regarding SCHs.

5. Sole community hospitals (SCH) appear to be poorly protected under current HCFA policies. For example, the special payment rate offered SCH facilities is often lower than their PPS payment rate. Thus, the SCH designation may offer eligible facilities with little or no additional financial protection, and it appears to serve little more than a "hold harmless" function.

5a. What additional financial protection should be offered for SCH facilities?

A. We believe that SCHs may not have not been adequately protected under the current statutory payment formula. As a result, we are currently evaluating alternative reimbursement policies to assist SCHs.

5b. Even with the changes proposed in HCFA's criteria for determining if a hospital qualifies for "volume protection", the process of obtaining this protection would be too lengthy. It might take as long as a year to actually receive higher payments. In view of the fragile financial position of many of these hospitals, even six months may be too long. Would HCFA be willing to explore a more expeditious interim payment plan following initial review and approval of a hospital's application by a regional office?

A. We have received very few requests for volume adjustments so far; less than 20 requests, nationwide. We review these cases centrally to assure that the requests are handled consistently. If the number of requests increases significantly, we will re-examine the review process.

Interim adjustments are made when a SCH's final cost report information is not available. In these instances, however, the cases have been reviewed to ensure that the SCH meets the criteria for a volume protection adjustment and, once the criteria are met, to calculate the maximum adjustment amount for which the SCH qualifies.

5c. Many rural hospitals believe the criteria for "volume protection" are too vague. Further, they have little information on how much additional money such "volume protection" payments will provide them. Please outline several sample cases using different criteria, the threshold HCFA would employ with the stated criteria, and the adjustments that would have been made.

A. We believe the criteria to qualify for a volume adjustment are clear. In addition to qualifying for SCH status and experiencing at least a five percent decline in discharges compared to last year, a hospital must demonstrate that the decline was caused by circumstances beyond its control. It must show a cause and effect relationship between the circumstances and the volume decline. And it must show how it reacted to the event and what action it took to control costs once it became evident that the circumstances would cause a decline in its discharges.

If the above criteria are met, we determine the maximum adjustment amount by calculating the difference between Medicare PPS payments (including outlier payments) and the Medicare inpatient operating costs. If payments have exceeded costs, no adjustment is warranted. We believe this is equitable since Medicare has already fully compensated the hospital for its costs of caring for Medicare inpatients. While it may be true that some SCHs are suffering financial hardship for other reasons, we believe it is clearly inappropriate for Medicare to share in costs attributable to non-Medicare patients.

If, however, Medicare costs exceeded Medicare payments, we look to see if the hospital took reasonable efforts to control costs in light of declining volume. Examples of such efforts include reducing staffing levels commensurate to declining volume (but within State-imposed levels) and reducing costs in related overhead cost centers (e.g. laundry and linen services, dietary departments, etc.) proportionate to declining volume.

Where appropriate, we have allowed hospitals a grace period of six months from the time the circumstance occurred and inpatient discharges began to decline until we would expect to see positive action to contain costs. The majority of the requests we have received have been based on a hospital's loss of essential physicians through events such as death, retirement, and transfer. In such situations, the "circumstance" beyond the hospital's control usually has a clearly defined onset date. Another "circumstance" often cited is severe economic hardship in the hospital's service area forcing area residents to shift to more prosperous areas and/or to delay inpatient admissions in all but the most serious situations. The exact starting date of the event is not evident in this instance and we have not penalized any hospital for failure to reduce costs unless it has failed to respond after it had become clear that the volume decline represents an on-going trend.

Typical examples follow:

- o SCH No. 1 - Requested adjustments for its fiscal years ending June 30, 1985 and June 30, 1986, based on volume declines of 39 percent and 20 percent respectively. The hospital cited the very poor farm economy as the circumstance beyond its control and showed that it had taken steps to lower its costs to minimum levels. Adjustments of $76,696 for 1985 and $68,143 were authorized. These amounts were the maximum permissible; the differences between Medicare PPS payments and Medicare operating costs.
- o SCH No. 2 - Requested an adjustment for its fiscal year ending September 30, 1986, based on a 27 percent decline in discharges caused by the illness and retirement of an essential staff physician. However, Medicare payments exceeded Medicare costs for the year by $260,075. Thus, no adjustment was granted.
- o SCH No. 3 - Requested an adjustment for its fiscal year ending September 30, 1984, based on a 35 percent decline in admissions due to the loss of two essential physicians. Although final cost report information was not available at the time, HCFA authorized an interim adjustment of $64,048 based on a preliminary trial balance submitted by the hospital. The amount represented the full amount permissible.

5d. Is HCFA providing SCH facilities with any technical and/or administrative assistance to help them improve their financial condition?

A. No. HCFA does not have the resources to provide SCH or other hospitals with assistance in improving their financial condition. Such a role is more appropriate for hospital associations, state agencies, and consulting firms.

6. A major issue facing Medicare beneficiaries who live in rural communities whose hospital has closed is access to acute care services. Has HCFA studied the impact of a hospital closure on beneficiary access in any such communities? If not, does HCFA intend to fund such studies in the near future?

A. HCFA is planning to fund a project to address exactly that issue. This project would take advantage of a data base, initially developed by the American Hospital Association, that has only recently become available to HCFA. The data base in question contains a verified list of hospitals that have closed during the period 1980 through 1986 (it is being updated through 1987), along with detailed information about each of these hospitals.

The study would be conducted by researchers at the Johns Hopkins University; they would compare utilization by three groups of enrollees -- those living in rural areas in which a hospital has closed during the 1980-86 period, those living in rural counties contiguous to rural counties in which a hospital has closed during this period, and those living in a selected comparison group of other rural counties.

We anticipate that this project will give us some preliminary information about the effect of rural hospital closures on access to health care by Medicare beneficiaries in the local and surrounding areas. In addition, we encourage other researchers who can contribute to the body of knowledge on this issue to apply for funding through our grants process.

7. As you know, the Conference Report for the Medicare Catastrophic Coverage Act further elaborated on the 10 percent set-aside for health care research in rural areas. What progress has HCFA made with respect to the rural health care research program?

A. Following the implementation of the Medicare hospital prospective payment system, HCFA initiated a number of projects designed to examine issues related to hospitals located in rural areas. Included among these studies were the following:

- o Sole Community Hospitals (Brandeis Research Center, $64,500) -- Report sent to Congress on November 27, 1987

- o Uncompensated Care Costs in Large Rural Teaching Hospitals (Brandeis Research Center, $132,000) -- Results used in "Rural Teaching Hospitals and Referral Centers" report sent to Congress on February 9, 1988; also used for "Uncompensated Care" report, currently in clearance in the Department
- o Urban/Rural Payment Differentials under DRGs (Brandeis Research Center; $32,285) -- Completed; used as theoretical basis for annual reporting as part of PPS Impact Report
- o PPS Impact on Rural Hospitals (Center for Health Economics Research; $334,000) -- Continuing
- o Longitudinal Studies of Local Area Hospital Use (University of Michigan; $214,000) -- Completed; no Report to Congress required
- o Rural Secondary Specialty Demonstration Lake Region Hospital (Minnesota) and Evaluation (Mathematica; $144,164) -- Continuing

We are also funding the following projects focusing primarily on health care in rural areas:

- o Preventive Health Care Services for Medicare Beneficiaries (University of Pittsburgh; awarded effective May 1, 1988 -- projected total funding $1,345,485) -- Continuing; sites are located in rural areas
- o Economy and Efficacy of Medicare Reimbursement for Preventive Services (University of North Carolina; projected total funding $1,674,522) -- Continuing; approximately one-third of sites are in rural areas
- o Evaluation of National Rural Swing Bed Program (University of Colorado; initially awarded in September 1983, project funding is being continued to respond to OBRA 1987 mandate; $1,181,824) -- Continuing; results used in report sent to Congress on February 5, 1988
- o Medical Assistance Facility (Montana Hospital Research and Education Foundation, Phase I (feasibility study) funding - $100,000) -- Continuing
- o Refining the Geographic Cost Index: Implications for Urban and Rural Areas (The Urban Institute, projected total funding $100,000)

In addition to these discrete projects, HCFA funds several large program evaluation efforts that focus on health care issues across settings. Included among these studies are the ongoing study of the impact of PPS on hospitals, beneficiaries, quality and access to care; and a series of studies designed to assess the issues of quality and access to care since the implementation of PPS, and to improve the methods we use to measure quality and access. These large program initiatives have, as one of their focuses, health care provided in rural areas.

To address the mandate in OBRA 87, as amended by the Medicare Catastrophic Coverage Act, we plan to commit 10 percent of the total obligations for research and demonstration projects that relate substantially or exclusively to rural health care issues. In FY 1989, assuming an appropriated budget level of $32 million, we estimate that $3.2 million would be targeted for rural health care research/demonstration projects including continuation of the ongoing projects included in the list above.

Specific steps we have taken to more clearly focus our research agenda on rural health care issues include the following:

- o Discussions with the Office of Rural Health Policy regarding potential areas of future research and demonstrations;
- o Increasing the emphasis on rural health care issues in our statement of funding priorities and solicitation for new projects for fiscal year 1989; and
- o A panel of experts in the field of rural health care was convened and developed a research agenda for studies of health services in rural areas. A report is to be published in the Fall. HCFA participated in this activity and plans to use the recommendations of the panel for development of its research agenda.

Although our ability to meet the proposed target spending level is directly dependent on receiving high quality, technically acceptable, and relevant applications, we are confident that these efforts will allow us to be responsive to the mandate.

8. What steps, if any, is HCFA taking to promote the formation of hospital cooperatives or other innovative arrangements to strengthen rural hospitals and help ensure health care access in rural areas?

A. You are already aware of our activities with regard to the proposal of the Montana Hospital Research and Education Foundation to establish a "Medical Assistance Facility" in certain frontier communities in Montana. In addition, Congress is considering appropriating funds for the implementation of a rural hospital transition grant program, which would provide matching funds to small rural hospitals that are interested in changing their "product" in response to a changing economic environment.

However, HCFA's fundamentally different mission as an insurer is to pay for the care provided to its beneficiaries, under both Medicare and Medicaid. Its responsibility is to strive for payments that are equitable to providers of care, while balancing Federal fiscal goals against ensuring access to high quality care. We will endeavor to respond quickly to changes in the hospital industry, as it adapts to cost constraints imposed by both private and public payers.

9. At the hearing, you announced that HCFA provided preliminary approval of the proposal for the Montana Hospital Research and Education Foundation to establish a "Medical Assistance Facility" in certain frontier communities in Montana. More specifically, full approval of the proposal was made conditional upon completion of a feasibility study, for which HCFA provided the Foundation $100,000 to carry out, and making certain changes to the proposal. In addition, approval of the Medicare/Medicaid waivers was deferred for a year.

9a. If the Foundation is able to comply with the changes HCFA outlined as needed before a year has passed, would HCFA be willing to grant the requested Medicare/Medicaid waivers at that time?

A. Because the problems facing rural health providers are varied and complicated, and because of the national policy implications of this project, we need a well defined proposal which thoroughly discusses the policy options and provides a well thought out research and evaluation design. The grants review panel felt the research design in the proposal was lacking in specific reimbursement and policy methodologies. Research questions were presented, but the project lacked an actual design. Another major weakness of the proposal was that the project is not well staffed. Thus, the panel recommended a phase-in approach with a feasibility study the first year to address the technical issues, including the payment formula, services covered, and the evaluation design and analysis plan.

Upon completion of the feasibility study, a determination will be made whether to approve the implementation of the demonstration. We fully intend to pursue waivers as soon as the technical issues can be addressed to the satisfaction of all parties, including the government.

9b. Is it correct to assume that if the Foundation meets all of HCFA's requirements and that the proposal therefore is fully approved, the $100,000 provided for the feasibility study will not be taken from the $440,109 budget needed to adequately fund the proposal?

A. In our June 9, 1988 award level to the Montana Hospital Research and Education Foundation, we made our approval contingent upon the resubmission within 90 days of an updated scope of work, redefined milestones, and revised plans for Phases I (feasibility study) and II (implementation phase). When the decision is made to continue with Phase II, we will evaluate the proposed budget for that phase and base our funding decision on the funds required to undertake and complete it, irrespective of the funds currently awarded to the feasibility study.

JOHN MELCHER, MONTANA, CHAIRMAN

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G. LAWRENCE ATKINS, MINORITY STAFF DIRECTOR

Item 7

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

May 23, 1988

The Honorable William L. Roper
Administrator
Health Care Financing Administration
Room 316-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Roper:

It is our understanding that your office is about to make final funding decisions on several pending health research grant proposals. We would like to take this opportunity to express our strong support for a project proposal submitted by the Montana Hospital Research and Education Foundation (MHREF), which requests funding and certain Medicare/Medicaid waivers to conduct a demonstration of the potential of medical assistance facilities to assure access to needed and more cost-effective health care in communities situated in frontier territories.

It is no secret that many hospitals in frontier areas are being forced to close their doors. These closures occur for a wide variety of reasons, including low utilization, high fixed costs, regulatory problems, and lack of success in attracting and retaining qualified health care personnel. As a result, citizens living in these areas are losing access to even the most basic of emergency and acute medical care.

In response to this critical problem, the Montana State Legislature recently created a new category of licensure for rural health facilities known as medical assistance facilities (MAFs). These health care facilities would provide short-term care in areas located in very low density populations or are at least 35 road miles from the nearest hospital. These downgraded hospital facilities would stabilize and provide essential care to persons prior to their discharge or, if necessary, transportation to a hospital. In our view, MAF's provide a preferable option to frontier hospital closures and have great potential to assure health care facility and personnel retention, thus assuring access to needed basic health care in frontier areas.

The goals of the MHREF proposal are as simple as they are critical. They are (1) to assist five very small frontier hospitals in deciding whether or not the option of downsizing to a MAF is in their best interest, and (2) to evaluate the utilization, cost, patient and provider satisfaction, and quality of services of the facilities that choose to become MAFs. At this time of great instability in the rural health community, we believe that it is essential that promising policy alternatives are fully explored. We believe that the MHREF grant proposal fits this criteria.

As Members of the Senate Special Committee on Aging who represent predominantly rural areas, we have a very strong interest in examining promising rural health care policy alternatives. In fact, we are planning to hold two Aging Committee hearings on this subject in June and July. Because we know you share our interest in assuring access to health care in rural frontier areas, it is our hope that you will give favorable consideration to funding the MHREF Medical Assistance Facility Demonstration Project.

Best regards.

Sincerely,

John Melcher
John Melcher
Chairman
Special Committee on Aging

Quentin Burdick
Quentin N. Burdick
Co-Chairman
Rural Health Caucus

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

JUL 1 1988

The Honorable John Melcher
Chairman, Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am responding to your letter concerning cooperative agreement application No. 95-C-99292/8-01, entitled "Medical Assistance Facility Demonstration Project," which was submitted by the Montana Hospital Research and Education Foundation (MHREF). Please accept my apology for the delay in responding.

This proposal, which was reviewed by a panel of experts, competed with 156 other applications submitted to the Office of Research and Demonstrations for the November 20, 1987 grant cycle. I am pleased to inform you that after careful consideration the application was approved. I have enclosed a copy of the letter that was sent to MHREF advising them of our decision and outlining the terms and conditions of Federal involvement.

Thank you for your continuing support and interest in our research and demonstration program. A similar letter is being sent to Senator Burdick.

Sincerely,

William L. Roper

William L. Roper, M.D.
Administrator

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

6325 Security Boulevard
Baltimore MD 21207

JUN 9

Mr. Anthony L. Wellever
Senior Vice President
Montana Hospital Research and
Education Foundation
P.O. Box 5119
Helena, Montana 59604

Dear Mr. Wellever:

We are pleased to inform you that we have approved the first year of the four year project, entitled "Medical Assistance Facility Demonstration Project." This project has been approved as cooperative agreement No. 95-C-99292/8-01, for the period of June 15, 1988 through June 14, 1989. Your application was reviewed by a technical panel which recommended approval of the application with the understanding that the project be modified. The panel recommended a phase-in approach with a feasibility study the first year to address the technical issues, including the payment formula to be used, services covered, and to design a project evaluation and analysis plan. Once these issues have been resolved, the implementation phase could begin.

In keeping with the panel's recommendation, we are awarding $100,000 for the first year's funding—Phase I of the project. Approval of this project is contingent upon the resubmission within 90 days of an updated scope of work, redefined milestones, and revised plans for Phases I and II. Our staff is available to work with you during this period, and one of our policy centers is also available for technical assistance. Upon completion of Phase I, a determination will be made whether to approve Phase II, the implementation, operation, and evaluation of the demonstration.

The Notice of Award is enclosed, along with the special terms and conditions which define the nature, character, and extent of anticipated Federal involvement in the project. This award, including the authority to begin the disbursement of funds, is subject to our receiving, within 30 days of the date of this letter, notification of your acceptance of the terms and conditions set forth in the enclosure. In addition, we have also included for your information a copy of the Department of Health and Human Services' guidelines for Administration of Grants (Part 74 of Title 45 of the Code of Federal Regulations).

Your project officer for the cooperative agreement is Mr. Victor McVicker, who can be reached at (301) 966-6681. Communications regarding program matters should be addressed to the project officer at the following address: Health Care Financing Administration, Office of Research and Demonstrations, Room 2302 Oak Meadows Building, 6325 Security Boulevard, Baltimore, Maryland 21207. Official correspondence concerning the cooperative agreement, including quarterly reports and continuation requests, should be submitted to Mr. Paul G. McKeown, HCFA Grants Officer, Health Care Financing Administration, Room 364 East High Rise, 6325 Security Boulevard, Baltimore, Maryland 21207; a copy of any such correspondence should also be sent to the project officer. Mr. McKeown is also serving as your Grants Management Specialist. He may be contacted for additional administrative matters at (301) 966-5157.

Please accept our congratulations on this award. We look forward to your continued cooperation during the course of this project.

Sincerely,

Joseph R. Antos, Ph.D.
Director
Office of Research and Demonstrations

Enclosures

COOPERATIVE AGREEMENT
SPECIAL TERMS AND CONDITIONS

NO : Cooperative Agreement No. 95-C-99292/8-01

TITLE : Medical Assistance Facility Demonstration Project

AWARDEE : Montana Hospital Research and Education Foundation
Helena, Montana

1. This is a cooperative agreement. The term "grant" should be construed as though it read "cooperative agreement." The special terms and conditions indicate the nature of the substantial Federal involvement anticipated during the performance of this agreement. Although 45 CFR Part 74 refers only to "grants," the term is defined broadly enough in Part 74 to include cooperative agreements and Part 74 is considered to apply to cooperative agreements.

2. The awardee will submit written progress reports no later than 30 days from the end of each quarter. The first quarterly progress report is due October 15, 1988.

3. A draft final report should be submitted to the HCFA project officer for comments. HCFA's comments should be taken into consideration by the awardee for incorporation into the final report. The awardee should use the HCFA, Office of Research and Demonstrations' Author's Guidelines: Grants and Contracts Final Reports (copy attached) in the preparation of the final report. The final report is due no later than 90 days after the termination of the project.

4. The HCFA project officer or designee will be available for technical consultation at the convenience of the awardee within 5 working days of telephone calls and within 10 working days on progress reports and other written documents submitted, such as the analysis plan.

5. The HCFA project officer shall provide advice and consultation on the methodology design, analysis plan, appropriate statistical treatment of the data, and outline of the final report.

6. The project officer does not have the authority to and may not issue any technical direction which (i) constitutes an assignment of additional work outside the general scope of the cooperative agreement, or (ii) in any manner causes an increase or decrease in the total estimated cost.

7. The awardee shall assume responsibility for the accuracy and completeness of the information contained in all technical documents and reports submitted. The HCFA project officer shall not direct the interpretation of the data used in preparing these [illegible] reports.

8. The awardee shall develop and submit detailed plans to protect the confidentiality of all project-related information that identifies individuals. The plan must specify that such information is confidential, that it may not be disclosed directly or indirectly except for purposes directly connected with the conduct of the project, and that informed written consent of the individual must be obtained for any disclosure.

9. HCFA may suspend or terminate any cooperative agreement in whole, or in part, at any time before the date of expiration, whenever it determines that the awardee has materially failed to comply with the terms of the cooperative agreement. HCFA will promptly notify the awardee in writing of the determination and the reasons for the suspension or termination, together with the effective date.

10. The HCFA project officer shall be notified prior to formal presentation of any report or statistical or analytical material based on information obtained through this cooperative agreement. Formal presentation includes papers, articles, professional publications, speeches, and testimony. In the course of this research, whenever the principal investigator determines that a significant new finding has been developed, he or she will immediately communicate it to the HCFA project officer before formal dissemination to the general public.

    The final report of the project may not be released or published without permission from the HCFA project officer within the first 4 months following the receipt of the report by the HCFA project officer. The final report will contain a disclaimer that the opinions expressed are those of the awardee and do not necessarily reflect the opinions of HCFA.

11. Certain key personnel, as designated by the HCFA project officer, are considered to be essential to the work being performed on specific activities. Prior to altering the levels of effort of any of the key personnel among the various activities for this project, or to diverting those individuals to other projects outside of the scope of this award, the awardee shall notify the HCFA project officer reasonably in advance and shall submit justification (including name and resume of proposed substitution) in sufficient detail to permit evaluation of the impact on the project. No alteration or diversion of the levels of effort of the designated key personnel from the specified activities for this project shall be made by the awardee without the approval of the HCFA project officer.

12. At any phase of the project, including at the project's conclusion, the awardee, if so requested by the project officer, must submit to HCFA analytic data file(s), with appropriate documentation, representing the data developed/used in end-product analyses generated under the award. The analytic file(s) may include primary data collected, acquired or generated under the award and/or data furnished by HCFA. The content, format, documentation, and schedule for production of the data file(s) will be agreed upon by the principal investigator and the HCFA project officer. The negotiated format(s) could include both file(s) that would be limited to HCFA internal use and file(s) that HCFA could make available to the general public.

13. At any phase of the project, including at the project's conclusion, the awardee, if so requested by the project officer, must deliver to HCFA any materials, systems, or other items developed, refined or enhanced in the course of or under the award. The awardee agrees that HCFA shall have royalty-free, nonexclusive and irrevocable rights to reproduce, publish or otherwise use and authorize others to use the items for Federal Government purposes.

APPENDIX 2

Item 1

AFFILIATED WITH THE AMERICAN HOSPITAL ASSOCIATION
MEMBER OF SOUTHEASTERN HOSPITAL CONFERENCE

LOUISIANA HOSPITAL ASSOCIATION

ROBERT D. MERKEL
PRESIDENT

9521 BROOKLINE AVENUE
P. O. BOX 80720 · (504) 928-0026
BATON ROUGE, LOUISIANA 70898-0720

June 16, 1988

Honorable John Melcher
United States Senate
Special Committee on Aging
Senate Dirksen Office Building
Room - G-41
Washington, D.C. 20510-6400

Dear Senator Melcher:

I would like to express the appreciation of the Louisiana Hospital Association for your invitation to Mr. Michael E. Cooper, Administrator, Richland Parish Hospitals, to appear before your Special Committee and allowing me to accompany him on Monday, June 13, 1988.

While my part in the hearing was negligible, I would appreciate the opportunity to present some additional material regarding questions posed by Senator Alan Simpson and other members. These comments are attached for your perusal and consideration for entry into the official record.

Once again, thank you for your efforts on behalf of rural hospitals. Should you have any further questions, please contact me.

Sincerely,

John Jurovich

John Jurovich
Vice President of Finance

JJ/cs

Enclosure

Statement of John Jurovich
to the United States Senate
Special Committee on Aging
on the Rural Health Care Challenge:
Part I Rural Hospitals

I am John Jurovich, Vice President of Finance, for the Louisiana Hospital Association and appreciate the opportunity to expand upon some of the Special Committee's concerns regarding rural hospitals. Firstly, it is extremely important for Congress to develop a national rural health care policy. A decision has to be made as to the nature and most appropriate role the community rural hospital must play in our society. Under current Medicare reimbursement methodology no specific role nor appropriate "incentives" are assigned for rural health care facilities. As a result of this, indiscriminant and wide spread closures of rural institutions may become common place in the very near future with a corresponding loss of access to predominantly the aged poor.

While Congress should be applauded for initiating steps (Pub.L. 100-203) to rectify the disparity between rural and urban payment rates under Medicare (urban/rural differential), more definitive remedies are seriously needed. A system that defines what the government desires in rural health care delivery and access must be developed with corresponding payment incentives. Reducing the payment differential between urban and rural providers while helpful does not address the problems being encountered. Increasing overall inpatient payment rates when a rural institution does not have any appreciable volume will not resolve the question of continued access. The Prospective Payment Assessment Commission (PROPAC) report contained in the May 27, 1988, Federal Register states that the steps already taken by Congress to reduce the urban/rural differential is sufficient. While this is true in part, more can be done.

A consideration in developing a national rural health care policy is whether or not rural hospitals should be encouraged to offer diversified in-patient services. Or should they be encouraged to only offer limited inpatient care with broad-based outpatient clinical and surgical services combined with long term skilled and/or custodial services. These issues should be addressed and appropriate compensation to provide the incentives implemented if rural health care is to continue.

If outpatient and skilled care services are deemed to be the most appropriate and cost efficient roles for rural institutions; then, steps should be taken to increase Medicare payment for outpatient surgical, radiology, laboratory and other services when provided in a rural setting. Increasing payment for outpatient services will more directly aid troubled rural facilities than decreasing the differential between urban and rural providers of health care. Outpatient ambulatory surgery reimbursement has not been adequately updated since 1982. Current Health Care Financing Administration (HCFA) draft rules on outpatient surgery are woefully inadequate to meet the needs of hospital providers.

Another important consideration that should be examined is the disproportional effects of financial risk undertaken by rural facilities in comparison to urban institutions. Specifically the dramatic losses that can be illustrated when a rural hospital encounters a "cost outlier." Many instances have occurred in Louisiana where a single cost outlier has totally destroyed a rural hospital's bottom line for an entire year and eroded strategic reserves. Such cases can be "catastrophic" on rural providers.

While HCFA's proposed rule (53 FR 19498, May 27, 1988) regarding outlier reimbursement is a major improvement over current payment rates, further refinement is necessary. This Committee is encouraged to lend its support of HCFA's proposed change provided HCFA reduces the outlier thresholds to more reasonable levels. This can be achieved by lowering the marginal cost factor to 60-65 percent instead of the proposed 80 percent. This will help rural hospitals in the short run, but further development of a "catastrophic loss" remedy should continue.

In summary, the task undertaken by this Committee is significant. The availability of adequate quality health care to the rural aged population is at stake. The current prospective pricing system under Medicare is unresponsive to the special circumstances involved in delivering health care in a rural community. A national rural health care policy with appropriate financial incentives must be developed if services to rural populations are to continue. The system as currently designed is totally indiscriminant as to which facility will close or remain viable and makes no association as to the necessity of any institution. Further changes to the urban/rural differential are not as important as adequate reimbursement for outpatient and skilled services and protection from "catastrophic losses."

The Special Committee on Aging has the unique opportunity to develope a cohesive national rural health care policy. It is hoped that further efforts will be pursued to assure that quality health care is available to our country's rural population.

Item 2

Communicating for Agriculture
Support Services

STATEMENT OF

BRUCE ABBE, DIRECTOR OF LEGISLATIVE AFFAIRS
COMMUNICATING FOR AGRICULTURE

SUBMITTED FOR THE RECORD TO THE
U.S. SENATE SPECIAL COMMITTEE ON AGING

HEARING ON THE RURAL HEALTH CARE CHALLENGE
JULY 11, 1988

Chairman Melcher, members of the committee, I extend my sincere appreciation to you for hearing the views of Communicating for Agriculture on matters that are of critical importance to the day-to-day lives of rural Americans and the viability of their communities.

During the two days of this hearing, you will have heard from many professionals who have particular experience in serving the health care needs of rural communities. I would like to share with you some of the concerns of the consumers -- the people who are served by and depend on rural health care system as it exists now and will evolve in the future.

Communicating for Agriculture is a national, non-profit, non-partisan public policy organization. We have nearly 40,000 member families, primarily farmers, ranchers and small town independent business people, in 40 states. We survey and represent our members on a wide range of issues, including rural development, rural education, and agricultural diversification. Rural health care has been a priority issue for Communicating for Agriculture from our beginning 15 years ago.

We want to thank you for holding these hearings and for a heightened awareness in Congress about the seriousness of access and affordability problems for health care in Rural America. We know that people in virtually every rural community have a deep concern about the status of rural health care. Most of all, they are concerned that their rural health care systems -- already inadequate in many areas --will degenerate into third class systems that lack necessary services, simply because distorted and unchecked economic forces are driving health care professionals and quality services to locate exclusively in populated areas.

There are two overall recommendations we would like to make concerning the issues that are the primary focus of this hearing -- access to care and shortage of professionals in rural areas:

1. **Congress should eliminate the clear cut discrimination against rural areas in federal Medicare reimbursement policies.** These policies are not a simple outgrowth of differences in a formula on delivery costs. They are, in fact, to a large extent the cause of many of the fundamental problems facing rural health care. The federal government is exacerbating a range of long-term problems on access to quality care in rural areas, and they won't be fixed until this unfair second class economic treatment is ended once and for all.

2. **Congress should recognize that the rural health care system is in transition and a more concerted federal effort is needed to assist and influence an evolution to a system that is better suited to meet future needs of local communities than what exists today.** More is needed than another pilot project. We need expansion of programs like the Rural Health Transition Grant Program and greater cooperation among federal, state and local authorities to design effective and appropriate systems for the future. If we are truly serious about addressing the problems of rural health care, then this can be a time of opportunity.

• • •

Forecasts of the number of hospitals that face closing over the next few years vary. A study Arthur Anderson and Company predicted that out of the 5,700 hospitals in the U.S., 700 will close by 1995 -- most of them small, rural hospitals. However, other knowledgeable organizations contend as many as 40 percent of rural hospitals are threatened with closure in the coming years.

If we could have confidence that the marketplace were serving up this fall-out on an orderly basis – one that would leave the right facilities in the right place to appropriately meet the needs of the public and eliminate only truly unneeded facilities, our concern would not be as great. But there is no evidence to suggest that is the case.

There are many factors that contribute to the problems of rural hospitals, but the discrepancies in Medicare reimbursement rates which pay rural hospitals far less than urban hospitals are consistently pegged as a predominant factor.

It is also the factor that is the hardest to understand, the least justifiable, and probably is the easiest policy problem to fix.

All of us are aware of the scope of the problems:

- Due to a formula set years back—in a different time with different circumstances—rural hospitals receive between 20 and 40 percent less from Medicare for the same treatment conducted by urban hospitals.

- Yet rural hospitals generally have a much larger share of Medicare patients in their patient mix. Many small rural hospitals derive 50 to 60 percent of their revenue from Medicare and Medicaid, levels which will lead to financial crisis for most facilities.

- The percentage of Medicare patients will continue to increase for rural hospitals and clinics because of the aging rural population. More than one-third of the elderly population in America currently lives in rural areas, compared to one-quarter of the overall population.

- **During the first three years of the Prospective Payment System which established the unequal rural/urban rates, 289 hospitals lost money under the Medicare program and more than 83 percent of them were rural hospitals.**

- Medicare reimbursement rates for non-hospital doctor procedures are also significantly lower for rural areas than urban areas. Is it any wonder that rural areas have greater difficulty in recruiting doctors, nurses and other specialists. As it stands now, the message to professionals is loud and clear – if you want to work at first class facilities, receive a fair wage and have a bright future, rural areas are not the place to go.

- While HCFA contends that treatment can be delivered at lower costs in rural areas, other studies show that medical treatment costs the same or more to deliver in rural areas. HCFA contends that rural providers prescribe "less intensive" care more frequently than urban providers for the same illnesses.

Rural consumers want and deserve access to the same high quality care as everyone else, but they are increasingly concerned that the financial squeeze is limiting the equipment, staff and capabilities of rural providers to give them equal care. **In short, they are concerned they are being forced to pay for the lower and unfair reimbursement rates to providers with poorer quality care.**

But in fact, they are paying for the discrepancies in many other ways.

- Medicare premiums paid by rural citizens are the same as those paid by urban residents, despite the fact that they receive a smaller proportion in reimbursement. **In essence, rural areas are subsidizing the Medicare payments made to urban areas.**

- Providers often attempt to make up for the losses they incur for indigent care and under-reimbursed care, such as Medicare and Medicaid, by "cost-shifting" the burden to regular business covered largely by standard health insurance. Rural providers point out they have less opportunity to cost-shift because they serve a larger share of uninsured and under-insured patients. Yet, some cost-shifting does occur. And that means that health insurers and other third-party payers who predominantly serve rural areas must in turn charge higher premium rates to make up for the difference. This directly impacts farmers and self-employed individuals who pay their own insurance costs...out-of-pocket.

- Hospitals are key part of the economic base of rural communities. Loss of jobs from hospital closings or cutbacks, lower wages for staff, and financial losses for facilities that lead to local subsidies, all have a crippling impact on the economies of rural communities.

A recent Oklahoma State University study found that a loss of 18 jobs at the hospital in the model community would lead to the loss of seven jobs in other sectors of the economy, primarily retail and service industries, within a year. Eventually it would result in the loss of 32 jobs overall only eight years down the road, due to a decline in population and demand for services.

By the same token, when businesses and people are locating in a new community, access to hospitals and quality health care services are always an important consideration. Community development efforts are significantly harmed when there is a real or perceived lack of health care services.

We are not saying that evening out Medicare reimbursement policies will fix all the problems facing rural health care. **We are saying that to the extent Medicare underpays rural areas, it exacerbates the many difficult financial problems rural health care providers already face. Simply put, the differences in Medicare reimbursement for rural and urban areas is discrimination -- unjust discrimination that harms rural consumers as much as it does rural medical professionals.**

Rural areas don't need "more equitable" reimbursement rates, they need equal reimbursement rates.

There are reasons why government programs, in some cases, should favor one sector or region of the country over others. It should be because that sector has greater need for help, and that the public good is best served by seeing that adequate public services and equal opportunities are provided to the people in the disadvantaged sector, even if it comes at a greater cost.

Rural communities were hit hard by the recession of the 1980s, and many have been left out of the recovery. There is a higher incidence of chronic illnesses and injuries resulting in death in rural areas. The need is there.

If anything, rural health care providers should be reimbursed at higher rates than urban areas. There is no justifiable reason why rural areas should be subsidizing the health care costs of urban areas.

* * *

We are not suggesting that every rural hospital be saved. There are outdated facilities that would cost too much to upgrade to the appropriate current standards. The decline of population in many rural areas has simply made it impossible for some areas to support their hospitals.

Rural health care today is in a state of painful transition. But a transition is needed and stronger steps should be taken to guide and support a transition to viable new health care systems that are geared to meet future needs of the community.

Many positive efforts are being taken around the country. A study by the University of Illinois noted that of recent hospital closings, one third have evolved into long-term nursing care and and ambulatory care centers. Some hospitals or underutilized hospital wings are being converted into special treatment centers for Alzheimer's Disease, and drug and alcohol abuse. Networks are being established among rural hospitals to see that needed specialized services remain accessible in an area, even though they may be dropped by one or more facilities. Mergers and links with large multi-hospital chains are being tried to try to obtain the economies of scale to keep operating.

There are a number of special demonstration programs underway. One good example is Montana's Medical Assistance Facility program, which seeks to see that emergency care and inpatient care for a limited period of time remain available in isolated communities where a hospital cannot be supported.

Farmers and ranchers, in particular, know that emergency services are a priority for any rural community, no matter how remote. Efforts like the MAF program may even improve emergency services for remote rural areas. For many Frontier areas, however, there likely will always be a need to provide for some subsidization of hospitals. Abandoning access to hospital care completely for these areas is a policy option that should not be taken.

The task of planning a transformation of health care facilities and services is a difficult task. It requires careful analysis of the population trends and future needs of the community; cooperation on the part of different providers in the system; and a good deal of leadership and often times bravery on the part of local officials.

We would urge the federal government to take a stronger role in supporting and encouraging a planned, coordinated transition in rural health care services.

Programs, such as the federal Rural Health Transition grant Program, which helps small hospitals modify their facilities, should be strengthened.

The National Health Service Corps, which provides training and brings doctors and other health care professionals to under-served rural areas should receive increased, not decreased funding.

In summary, rural health care consumers want to have health care systems that are dependable and tailored to meet the needs of their changing population. They understand that changes are necessary, but they expect that basic needed services will exist in their communities, full services will be accessible to them within reasonable distances, and that all of the services will be second to none in quality. The first and foremost step in that direction is for the federal government to eliminate the inequitable Medicare reimbursement rates which treat rural providers and consumers as second class citizens.

Thank you.

APPENDIX 3

Item 1

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION
300 7th Street, S.W. Washington, D.C. 20024 (202) 453-3986

Stuart H. Altman, Ph.D.
Chairman

Donald A. Young, M.D.
Executive Director

June 15, 1988

Honorable John Melcher
Chairman
Special Committee on Aging
U.S. Senate
Washington, DC 20510

Dear Senator Melcher:

Enclosed is a copy of the report An Evaluation of the Department of Health and Human Services' Report to Congress on Studies of Urban-Rural and Related Geographical Adjustments in the Medicare Prospective Payment System. This report has been prepared by the Prospective Payment Assessment Commission as required by Section 4009 (h)(1) of Public Law 100-203.

Sincerely,

Donald A. Young, M.D.
Executive Director

Enclosure

AN EVALUATION OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES' REPORT TO CONGRESS ON STUDIES OF URBAN-RURAL AND RELATED GEOGRAPHICAL ADJUSTMENTS IN THE MEDICARE PROSPECTIVE PAYMENT SYSTEM

PROSPECTIVE PAYMENT
ASSESSMENT COMMISSION
June 1988

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION
300 7th Street, S.W. Washington, D.C. 20024 (202) 453-3986

Stuart H. Altman, Ph.D.
Chairman

Donald A. Young, M.D.
Executive Director

June 13, 1988

The Honorable Jim Wright
Speaker
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

I am hereby transmitting to the Congress the report *An Evaluation of the Department of Health and Human Services' Report to Congress on Studies of Urban-Rural and Related Geographical Adjustments in the Medicare Prospective Payment System*. This report has been prepared by the Prospective Payment Assessment Commission as required by Section 4009(h)(1) of Public Law 100-203.

The Honorable George Bush
President of the Senate
United States Senate
Washington, D.C. 20510

Dear Mr. President:

I am hereby transmitting to the Congress the report *An Evaluation of the Department of Health and Human Services' Report to Congress on Studies of Urban-Rural and Related Geographical Adjustments in the Medicare Prospective Payment System*. This report has been prepared by the Prospective Payment Assessment Commission as required by Section 4009(h)(1) of Public Law 100-203.

Sincerely,

Stuart H. Altman, Ph.D.
Chairman

Enclosure

OVERVIEW

The legislation creating the Medicare prospective payment system (PPS) required the Secretary to study the feasibility and impact of eliminating or phasing out separate urban and rural rates. The Congress recognized that the final decision regarding separate rates would ultimately be a policy judgment, rather than a finding that could be arrived at solely through examination of data. To make this decision, however, it required information on the effect of moving to a single national rate. The Secretary's report was to provide this information. The Omnibus Budget Reconciliation Act of 1987 (OBRA 87) required the Prospective Payment Assessment Commission to report to the Congress on its evaluation of the Secretary's study.

The Secretary submitted his report on December 24, 1987. The report covers a number of issues in addition to the separate urban and rural rates. These are retention of regional or hospital-specific rates, refinements of the wage index, and alternatives to maintenance of separate rates. The Secretary's report does not include specific recommendations on separate rates. Instead, it suggests that there is a need to refine the PPS formula to include continuous adjustments (similar to the area wage and case-mix adjustments) that could be used to adjust a single rate. The Health Care Financing Administration (HCFA) is examining the feasibility of using indexes based on either referral or transfer patterns as a more sensitive alternative to separate rates.

The Commission's report responds to the OBRA 87 mandate and focuses on the Secretary's findings regarding separate urban and rural payment rates. It is organized into four major sections:

- Background and Definition of Issues
- Summary of the Secretary's Study Methods and Findings
- Commission Evaluation of the Secretary's Study
- Future Direction of Commission Activities

The Commission makes no recommendation, either for maintaining or eliminating separate urban and rural rates. The Commission believes that, before it can develop a recommendation, it must better understand the reasons for the approximately 40 percent difference in average Medicare cost per case between urban and rural hospitals. This cost difference was present when the PPS rates were first established and has continued through at least the third year of PPS, the most recent year for which Medicare cost data are available.

The 40 percent cost difference is roughly paralleled by a 40 percent difference in average PPS per-case payments to urban and rural hospitals. This payment difference is only partly attributable to the difference in the urban and rural standardized amounts. Other factors in the payment formula, most notably the difference in the urban and rural average wage and case-mix indexes, also contribute to the difference in per-case payments.

These cost and payment differences are part of a broader set of issues that have not been addressed by the Secretary. In particular, a thorough discussion needs to ensue as to the appropriate criteria by which to judge the fairness of the payment system.

The discussion also needs to address which variations in geographic practice patterns should be reflected in the PPS payment system. The issue is whether PPS payments should continue to reflect poorly understood geographic practice pattern variations that cannot be attributed to measurable differences in patient characteristics, quality of care, or market area features that are beyond the control of an individual hospital. The issue is complicated by the unknown relationship between practice pattern variations, revenues, costs and quality.

The Commission plans to continue its examination of these issues and incorporate its findings into future reports. Alternatives to separate rates will be explored as a part of the Commission's overall analytic agenda examining all aspects of PPS payment policy.

BACKGROUND AND DEFINITION OF ISSUES

In December 1982, the Secretary of Health and Human Services submitted to Congress a report outlining the design of a Medicare prospective payment system for inpatient hospital services. This report was mandated by Congress under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

The 1982 report outlined the basic dimensions of the Medicare prospective payment system. Hospitals were to be paid on the basis of DRGs; adjustments were to be made for area wage differences and teaching activity; extra payments were to be made for patients with very long lengths of stay or very high costs; and payments for direct medical education and capital were to be based on individual hospital costs.

The Secretary's proposal would have paid hospitals based on a single national rate for each DRG. This stands in contrast to the separate national and regional rates for urban and rural areas ultimately adopted by Congress. Analyses of the Administration's proposal revealed that immediate movement to a single national rate would lead to major redistribution of payments. The Congress' decision for separate urban and rural rates, regional rates, and a transition to national rates moderated the redistributional effects.

The Congress was interested in determining the impact of adopting a single national rate once hospitals had gained some experience with PPS. This interest resulted in the mandate to the Secretary to conduct the study which is the subject of the Commission's report.

SUMMARY OF THE SECRETARY'S METHODS AND FINDINGS

Congress required the Secretary to address the feasibility and impact of phasing out or eliminating separate urban and rural payment rates. The Secretary's report addresses several issues beyond separate payment rates for urban and rural hospitals. With respect to separate payment rates, however, the report appears to have two major objectives:

- to evaluate the financial impact on urban and rural hospital groups of eliminating separate rates, and
- to suggest alternatives to the current separate urban and rural payment rates.

The Secretary's evaluation focuses on the equity implications of eliminating separate rates. The Secretary's report, however, does not explicitly discuss alternative criteria and measures to evaluate equity. Instead, the report uses one criterion -- Medicare operating margins -- as the bench mark for evaluating the fairness of the payment system. The Secretary's report also does not explicitly address the criteria for judging whether a change in policy should be made. The remaining portion of this section outlines the methods and findings used in the Secretary's report.

Definition of Payment Equity -- Medicare Operating Margins

The Secretary argues that, ideally, payment equity could be assessed by comparing PPS payments with the efficient costs of treating Medicare beneficiaries. The Secretary defines an "ideal Medicare operating margin" as the difference between PPS operating revenue and efficient operating costs, divided by efficient operating costs. Payment equity would result in all hospitals having equal ideal Medicare operating margins, although their actual margins may not be equal.

Since efficient costs are unknown, the Secretary argues that Medicare operating margins, based on actual Medicare costs, represent a reasonable measure of the relative fairness of PPS. The Secretary's argument is as follows.

> "If it could be assumed that PPS has forced most hospitals to be as efficient as possible, then differences in the operating margins among groups of hospitals could be attributable to factors which are beyond the control of the hospital (i.e., payment formula inequities). In addition,

> if inefficiency is largely not correlated with other hospital characteristics such as size and location, then focusing on operating margins for groups of hospitals would reduce the chances of confusing differences in efficiency with payment formula inequities. Consequently, imperfect as it may be, the differences in the group operating margins will be used in this report as the best available indicator of a need for refinement of the PPS payment formula."[1]

Therefore, the report's analyses are based on the assumption that fairness can be judged by examining Medicare operating margins. The Secretary defines these margins as follows:[2]

$$\text{Operating Margin} = \frac{\underline{\text{PPS Revenue} - \text{Medicare Operating Costs}}}{\text{Medicare Operating Costs}}$$

The analyses are intended to measure relative differences in Medicare margins, not absolute levels of margins. They reflect the relative cost differences that existed among hospitals in the first PPS year, updated by a constant percentage increase applied to all hospitals. Thus, the analyses assume that all hospitals experienced exactly the same percent changes in cost per case since the first year of PPS. The Secretary acknowledges that findings from more recent studies show hospitals' cost experience varying with the level of payment.

Methods

The analyses in the Secretary's report are based on a microsimulation model developed by the Health Care Financing Administration (HCFA). The model estimates PPS operating payments to individual hospitals under alternative policies and projects both payments and costs to Federal fiscal year 1988. Medicare margins are reported for different groups of hospitals.

The model assumes a fully phased-in national payment rate system, governed by policies included in the final rule for fiscal year 1987 (Federal Register, November 24, 1986), but with payments based on case-weighted rates as required by the Omnibus Reconciliation Act of 1986. These rules were assumed to be equivalent to those that would be implemented when the Secretary issued the final rule governing fiscal year 1988 payments. The analyses were performed prior to the Secretary's issuance of the final rule.

Payments to individual hospitals were estimated using the expected national urban and rural standardized payment amounts, multiplied by the applicable wage index, case-mix index and the number of Medicare discharges derived from the fiscal years 1984 and 1985 MEDPAR files. Additional payments for outliers, teaching, and disproportionate share adjustments were estimated. All hospitals' Federal fiscal year 1987 case-mix indexes, resident-to-bed ratios and disproportionate share adjustment factors were assumed to be identical to their values in the first year of PPS.

Hospital costs were based on data from the first year of PPS. Hospitals do not necessarily follow the same fiscal year accounting cycle as the Federal government. To facilitate analyses, hospital costs were adjusted to coincide with the Federal fiscal year. The first-year PPS Medicare cost data were deflated to September 30, 1983 and trended forward to September 30, 1987 by HCFA's market basket inflation factor.

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[1] Bowen, O.R., Report To Congress: Studies of Urban-Rural and Related Geographical Adjustments in the Medicare Prospective Payment System (Washington, DC: U.S. Department of Health and Human Services, December 24, 1987) 2.2-2.3.

[2] In standard accounting terms, the operating margin would be defined as PPS revenues, minus Medicare operating costs, divided by PPS revenues. The Secretary's definition of the operating margin is technically referred to as the "mark-up ratio."

All the simulations were conducted so that the overall national margin remained constant. Moreover, the costs used in the simulations reflect first-year PPS costs updated by increases in the market basket, which are significantly below recent increases in actual hospital costs. Thus, the margins reported do not reflect absolute levels of Medicare margins but the relative changes in urban and rural margins due to policy changes.

The report also summarizes the findings from two studies on the impact of practice pattern and severity differences on hospital costs. The first study compared patients who were admitted to the faculty services and community services of a major university-affiliated hospital.[3] The second study attempted to determine the extent to which the observed cost variation among urban and rural hospitals were due to differences in patient severity of illness versus practice pattern styles.[4] This study found that physicians in urban hospitals practice a more technology-intensive style of practice that is unexplained by DRG case mix or patient severity.

Study Findings

Based on the microsimulation model, HCFA analyzed the impact of recent changes in federal policy on the estimated fiscal year 1988 margins as well as the impact of eliminating separate rates entirely. The Secretary's analyses and conclusions are summarized below:

- The legislative provisions in the Omnibus Budget Reconciliation Act of 1986 (OBRA 86) will correct the systematic bias against rural hospitals that prevailed under prior PPS policies.

  OBRA 86 legislated separate urban and rural adjustments to the standardized amounts for outliers, and replaced hospital-weighted DRG payment rates with case-weighted rates. The pre-OBRA simulations show a significant difference between the operating margins of urban and rural hospitals -- 13.8 percent for urban versus 6.7 percent for rural. Under the post-OBRA system with separate urban and rural rates, PPS operating margins are simulated to be 12.8 percent for urban compared to 11.9 percent for rural hospitals.

- The rate adjustments required by OBRA 86, however, do not redress many of the distributional problems identified.

  Under current law, several groups, including some that receive special treatment under PPS, are expected to continue to have substantially greater Medicare margins -- small rural hospitals with less than 50 beds, and disproportionate share, rural referral center and teaching hospitals. Sole community hospitals would continue to have margins significantly below the rural average (4.9 percent).

- "Rebasing" the post-OBRA rates is unnecessary because OBRA will have corrected for most of the disparity between rural and urban hospital margins. The Secretary argues that rebasing would overcorrect for the remaining disparity, resulting in rural hospital average margins exceeding the urban hospital average.

  Rural hospitals would benefit if new urban and rural rates were computed using first-year PPS cost data. "Rebased" rates were computed using first-year data and adjusted so that total payments would not be affected -- only the relationship between urban and rural rates would change. Using these rates, simulated rural margins rise from 11.9 percent to 15.6 percent. Simulated urban margins fall from 12.8 to 12.0 percent.

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[3] Garber, A., Fuchs, V., and Silverman, J. "Case Mix, Costs, and Outcomes: Differences between Faculty and Community Services in a University Hospital." New England Journal of Medicine, 310(19): 1231-1237, 1984.

[4] Cromwell, J., Hendricks, A., and Pope, G., Report on Geographic Refinements to PPS Payment Adjustment, HCFA Contract No. 500-85-0015, September 1986.

- Moving to a single national rate would redistribute payments from urban to rural hospitals.

  On average, urban hospitals would experience 10.6 percent margins compared to 22.1 percent margins for rural hospitals. Small rural hospitals with less than 100 beds would be particularly advantaged with an estimated average margin of over 30 percent.

- Systematic differences in practice patterns exist between urban and rural hospitals.

  Systematic practice pattern differences result in higher costs in urban compared to rural hospitals, even after adjustments are made for case mix, area wages, severity and teaching. These differences are only partially reflected in the separate PPS rate structure. Moreover, the current system of separate rates is insensitive to the significant variation in hospital practice patterns and financial status within the larger averages for urban and rural hospitals. The system effectively labels all rural hospitals (with the exception of rural referral centers) "low cost" and all urban hospitals as "high cost."

In summary, the Secretary concludes that problems exist with the current approach of separate urban and rural payment amounts. Eliminating the separate rates, however, would only increase the disparity among different classes of hospitals. Rather, the results suggest that there is a need to refine the PPS formula to include continuous adjustments (similar to the area wage and case-mix adjustments) that could be used to adjust a single rate. These should be designed to reflect differences in styles of practice among urban and rural hospitals in a more graduated fashion. Such measures would avoid the "boundary problems" of the separate urban and rural rate structure. HCFA is currently examining the feasibility of using indexes based on either referral or transfer patterns as a more sensitive alternative to separate rates.

COMMISSION EVALUATION OF THE SECRETARY'S REPORT

Based on its evaluation of the Secretary's report, the Commission has concluded the following:

- Payment Equity -- Medicare margins alone provide an inadequate measure of payment equity.

- Data Vintage -- Conclusions regarding relative urban and rural margins are limited by the use of first-year PPS data and the simulation model's assumption that hospital per-case costs would increase at the market basket inflation rate.

- Impact of Recent Policy Changes -- Commission studies verify the Secretary's conclusion that a major redistribution of payments will result from recent PPS policy changes.

- Movement to a Single National Rate -- Commission simulations support the Secretary's conclusion that eliminating separate urban and rural rates would result in a major redistribution of payments from urban to rural hospitals.

These conclusions are discussed in greater detail below.

Payment Equity

The Secretary has relied on a method of determining relative Medicare margins to judge the equity of the current payment system. The report implies that a reasonably equitable system is one in which Medicare margins across broad groups of hospitals are equal.

The Commission believes that the analysis needs to go beyond margins to assess whether payment equity has been achieved. Over time, analyses must examine whether the appropriate sources of cost variation are being recognized in the payment system. The analyses must look behind the observed differences in hospital margins to examine separately the impact of hospital revenues and costs. The success of these analyses in the formulation of policy depends on the availability of adequate measures of case mix, patient severity and outcome, and other factors contributing to cost variation.

Beyond the analyses, however, certain fundamental issues need to be addressed before changes in payment policy can be formulated.

In particular, a thorough discussion needs to ensue as to the appropriate criteria by which to judge the fairness of the payment system. The discussion also needs to address the extent to which PPS payments should reflect geographic practice pattern variations.

There has been general consensus that PPS payments should reflect, where possible, cost variations due to differences in patient characteristics, such as diagnosis, severity and complexity, as well as differences in area wages and other factors that are beyond a hospital's control. The adjustments in the PPS formula for DRG case mix, area wages, teaching activity and disproportionate share attempt to account for some of these factors. In addition, the separate urban and rural rates attempt to account for costs associated with practice pattern variations which are poorly understood.

The issue is complicated by the unknown relationship between practice pattern variations, costs and quality. Thus, if higher average costs and greater intensity in urban hospitals reflect unmeasured differences in patient characteristics and quality, a single rate system may underfund urban hospitals. On the other hand, lower historic average costs and intensity may not reflect rural hospitals' current need for technologically sophisticated services to compete with their urban counterparts in providing high quality care. Under these circumstances, it could be argued that separate payment rates may underfund rural hospitals that are not referral centers.

These issues are not addressed by the Secretary. The Commission recognizes that they are difficult issues that elude simple answers. Yet, these are the types of issues that need to be answered before the desirability of adopting an alternative to the current urban and rural rate structure can be evaluated.

Data Vintage

All simulations in the Secretary's report are based on first-year PPS cost data trended forward by HCFA's market basket inflation factor. As such, the analyses do not account for the dramatic decline in margins and changes in the cost experiences of hospitals since that first year.

ProPAC studies show that PPS margins fell dramatically in the third year of PPS -- from 15.2 to 8.9 percent for urban hospitals and from 8.7 to 4.6 percent for rural hospitals. The decline has not been uniform across the different types of urban and rural hospitals, however. For example, rural hospitals, other than sole community and rural referral centers, experienced a drop in their average margin from 6.9 percent to 0.9 percent. At the same time, hospitals in urban areas with over a million people experienced a less sharp decline (from 14.6 percent to 7.8 percent), and rural referral centers experienced an increase (from 14.8 percent to 15.3 percent).

In addition to constraints on payment, the third year margin declines can be traced to per-case cost increases that were significantly above HCFA's 2.9 percent market basket inflation factor. In the third year of PPS, rural and urban per-case costs increased 11.8 and 9.8 percent, respectively. The greater increase in rural per-case costs can be partially attributed to greater volume declines. In the third year of PPS, rural hospital Medicare operating costs increased only 5.6 percent but Medicare cases declined 5.6 percent. At the same time, urban hospital Medicare operating costs increased 6.7 percent but Medicare cases only declined 2.8 percent.

Thus, since the first year of PPS, hospitals have undergone a series of changes in their margins, costs, and volume that are not accounted for in the Secretary's simulation. Further information related to these changes is included in the Commission's June 1988 report, Medicare Prospective Payment and the American Health Care System.

Impact of Recent Policy Changes

A series of legislative changes have increased PPS payments to rural hospitals relative to urban ones. Separate outlier pools were established so that rural hospitals no longer contribute to the outlier payments of urban hospitals. Payment rates are case-weighted so that very small, very low cost hospitals contribute relatively little to the average rate.

The combined effect of these two changes increased per-case PPS payments to rural hospitals by about 5 percent. In addition, OBRA 87 authorized a higher update factor to rural hospitals for fiscal years 1988 and 1989.

The Commission's analyses confirm the Secretary's findings that, in the absence of other changes, the combined effect of the recent policies would remove the overall differential between Medicare operating margins for urban and rural hospitals. On the other hand, if rural hospitals continue to experience greater volume declines than urban hospitals, the margins for rural hospitals may continue to be lower. Greater volume declines could result in larger per-case cost increases for rural than urban hospitals. The larger rural cost increases would at least partially offset the payment increases legislated for these hospitals under OBRA 87.

Nevertheless, the Commission concurs with the Secretary's conclusion that the OBRA changes significantly improved payment equity. The differential between urban and rural payment rates and margins are likely to be further reduced by differential updates. The Commission also agrees, however, that substantial distributional problems remain within the broad categories of urban and rural hospitals.

Movement To A Single National Rate

The Secretary rejected eliminating separate rates because a single national rate would increase the disparity between urban and rural hospital margins. Commission analyses suggest that movement to a single national rate would significantly increase rural and decrease urban margins, all other factors being equal.

Commission analyses confirm the Secretary's finding that eliminating separate urban and rural rates is likely to redistribute payments to rural hospitals. If a single rate were adopted, the Commission estimates that payments to rural hospitals would increase approximately 11.5 percent while payments to urban hospitals would decrease 1.6 percent. These estimates assume that a single rate would be implemented without affecting total PPS payments.

The Secretary's report goes on to suggest that continuous adjustments for practice pattern differences need to be developed which could then be applied to a single national rate. The movement to a single national rate is consistent with recent public policy to create differential update factors that narrow the differences in payment between urban and rural rates. It is also consistent with the decision to complete the transition to national rates that eliminated separate regional payments.

The Secretary does not, however, propose any changes in the interim while these ideal adjustments are developed. Nor does the Secretary provide evidence that the methods under study for such adjustments would be appropriate and fair for all hospitals.

FUTURE DIRECTION OF COMMISSION ACTIVITIES

Average PPS payments per case to urban hospitals are approximately 40 percent higher than rural hospital payments. This difference is only partly attributable to the difference in the urban and rural published standardized payment rates. Other factors in the payment formula, most notably the difference in the urban and rural case-mix indexes, also contribute to the difference in per-case payments.

The 40 percent PPS payment difference roughly parallels the difference in urban and rural hospital average Medicare per-case costs that existed at the time the PPS payment rates were established. This cost difference has continued through at least the third year of PPS, the most recent year for which Medicare cost data are available. The Commission believes that the reasons for the substantial cost differences between urban and rural hospitals need to be better understood before a decision on separate urban and rural payment rates can be made. Analyses also need to be conducted using more recent cost data.

After reviewing the Secretary's report and its own analyses, the Commission does not believe it has sufficient information to make a recommendation. In the coming months, the Commission plans to continue to examine the issue of separate urban and rural rates. Alternatives to separate rates will be explored as a part of the Commission's overall analytic agenda examining all aspects of PPS payment policy.

As a part of this examination, the Commission plans to devote more attention to basic questions regarding the extent to which PPS payments should reflect practice pattern variations. The issue is whether PPS payments should continue to reflect poorly understood geographic variations in practice patterns that cannot be attributed to measurable differences in patient characteristics, quality of care, or market area features that are beyond the control of an individual hospital. The Commission will incorporate its findings and judgments on these issues into future reports.

Item 2

American Hospital Association

AHA

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August 2, 1988

The Honorable John Melcher
Chairman
Senate Special Committee on Aging
G41 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Melcher:

It is my pleasure to forward you a new AHA publication, the Profile of Small or Rural Hospitals: 1980-1986. This document summarizes the many issues raised during recent hearings conducted by your committee regarding rural health care issues. I believe committee members will gain a great deal by reviewing our summary of the difficult financial situation faced by small or rural hospitals.

AHA's Section for Small or Rural Hospitals is encouraged by your committee's interest in both the institutions and the individuals providing care in rural America. Although we made great strides in 1987, a great deal more work remains to be done. We are currently working to secure appropriations for the Rural Health Transition Grant program, to address the problem of manpower shortages in rural areas and to prepare for 1989. AHA is currently developing a package of improvements to the Medicare system. One key element of that package will call for the elimination of the urban-rural prospective payment differential. We will keep you apprised of our progress on this proposal.

Thank you for your support in the critical issues facing our rural hospitals.

Sincerely

Jack Owen

Jack W. Owen
Executive Vice President
Washington Office

A publication for AHA member institutions

Profile of Small or Rural Hospitals 1980-86

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FOREWORD

The second edition of the American Hospital Association's Profile of Small or Rural Hospitals has been updated to include information gathered between 1980 and 1986. It is intended to answer the following commonly asked questions:

- **How can small or rural hospitals be described?**
- **What key health care trends are affecting small or rural hospitals?**
- **Can differences be seen in information collected between 1980 and 1983 (before prospective pricing began) and between 1984 and 1986?**

Production of this profile is the result of a combined effort by AHA's Section for Small or Rural Hospitals and AHA's Division of Strategic Planning and Marketing. The data represent the experience of community registered hospitals and were developed from 1980–1986 editions of the American Hospital Association's Annual Survey of Hospitals.

As vice-president, I am pleased to see the publiication of the second edition of this profile. It is intended as a resource for hospital administrators, staff, and governing boards, providing an opportunity to review and compare aggregate data from small or rural hospitals throughout the country and make comparisons with individual institutions. Legislative and health policy decision makers at the community, state, and federal levels may also benefit from this descriptive characterization of small or rural hospitals.

It is our intent to continue to update this profile periodically in order to provide relevant and current information to those concerned about small or rural hospitals and health care.

James G. Schuman
Vice-President
American Hospital Association
July 1988

ACKNOWLEDGMENTS

The Profile of Small or Rural Hospitals 1980–1986 was written by Deborah Reczynski and Belva Denmark Tibbs of the AHA Division of Strategic Planning and Marketing. The following AHA staff members also contributed to the development of this report: Robert Bergmann and Robert Davis, Hospital Data Center; Sylvia Boeder, Section for Small or Rural Hospitals; and DiAnn Thompson, Division of Strategic Planning and Marketing.

INTRODUCTION

Environmental Forces

In the 1980s, a number of significant changes have affected the environment in which hospitals operate:

- Federal, state, and local governments, as well as private payers have introduced major efforts to contain health care costs. Medicare prospective pricing was introduced in 1983, a number of state governments have implemented prospective pricing systems for Medicaid or are contracting with HMOs or other prepaid health plans to provide care for Medicaid recipients, prepaid health plans have risen substantially in number and enrollment, and private payers are incorporating more managed care features into their coverage plans and are negotiating more often with hospitals for more favorable payment arrangements.
- More care is being provided on an outpatient basis as a result of increased payer encouragement, consumer acceptance of ambulatory care, changing patterns of medical practice, and expanded hospital outpatient services.
- Hospitals are competing more with other hospitals, multihospital systems, physicians, and other health care providers for patients.

- A major shortage of registered nurses has developed, which is likely to worsen as nursing school enrollments continue to decline. For rural hospitals, the nurse shortage may be especially severe. Rural hospitals have always had problems competing with large hospitals for nurses, as well as for other health professionals. These problems are compounded by payment differentials in Medicare's prospective pricing system and higher salaries that may be required in a competitive labor market.
- The aging of the U.S. population is creating increased demand for chronic long-term health and life care services.
- Changes in medical practice, increased consumer education, and risk identification in the workplace have led to a greater emphasis on creating and maintaining healthy lifestyles.
- Consumers are more aware of health care options and costs.

Factors Affecting Rural America

Other environmental factors that particularly affect hospitals in rural areas include ongoing economic problems, slower growth in population, and high concentrations of elderly and poor residents in rural America.

- The economy of rural America is heavily dependent on the agricultural, manufacturing, mining, and oil and energy industries. These industries experienced severe problems in the 1980s, largely because of increased competition with foreign producers. High domestic real interest rates and sharply falling farm asset values also contributed to problems in agriculture. Although the outlook for farmers has improved recently, the problems are by no means over. Foreign competition is unlikely to ease, given continued low demand, low prices, and growing foreign production. Although the federal government has increased financial aid to farmers, many economists and farmers believe that such assistance may encourage overproduction and drive prices down further.
- Following unusually rapid growth in the 1970s, the rural population is again growing at a relatively slow rate. The number of rural residents rose an average of 1.4 percent per year between 1973 and 1979, but average annual growth dropped to 0.9 percent in the period from 1979 to 1984. Prospects for immediate population growth in rural areas appear slim in light of rural economic problems.
- In 1986, the elderly, or those aged 65 years and over, accounted for 14 percent of the rural population, compared with 11 percent of the urban population. Poverty rates also tend to be higher in rural areas. In 1985, 18.3 percent of the rural population fell below the federal poverty level, while 12.7 percent of the urban population did so. The difference is greater among the elderly; 17.6 percent of the rural elderly live in poverty, compared with 10.9 percent of the urban elderly.

Hospital Responses

Small or rural hospitals are responding to environmental pressures in the following ways:

- In response to fluctuations in patient volume, hospitals have reduced staff and beds and have substituted part-time employees for full-time employees.
- To gain access to new technology, achieve economies of scale in purchasing and other areas, and improve access to capital, many small or rural hospitals have entered into shared service or networking arrangements with other rural or urban providers, or have joined multihospital systems or alliances.
- To stabilize patient volume and revenue and better meet community needs, many hospitals have introduced or expanded various ambulatory and nonacute care services, including home care, health promotion, and long-term care.
- Small or rural hospitals are extending the continuum of care through such services as swing beds, discharge planning, home health care, and hospice care.
- Small or rural hospitals are investigating physician joint ventures or preferred provider arrangements with local businesses or industries.

SMALL OR RURAL HOSPITAL CHARACTERISTICS

Composition

Small or rural hospitals provide a substantial amount of the nation's health care services. In isolated areas, they may provide the only health care available. Small or rural hospitals are usually major area employers and contribute greatly to the financial and economic stability of the communities they serve.

In 1986, 3,656, or 64 percent, of U.S. community hospitals were designated by the American Hospital Association as small or rural. Small hospitals include those having fewer than 100 acute care beds or 4,000 or fewer annual admissions. Rural hospitals are those located outside a metropolitan statistical area. Approximately 46 percent, or 2,638, of community hospitals in the United States are designated as rural. Approximately 1,018, or 18 percent, of total U.S. community hospitals are classified as small urban. Of all small or rural hospitals, 72 percent are classified as rural and 28 percent are classified as small urban (see figures 1, 2, and 3, and table 1).

Ownership

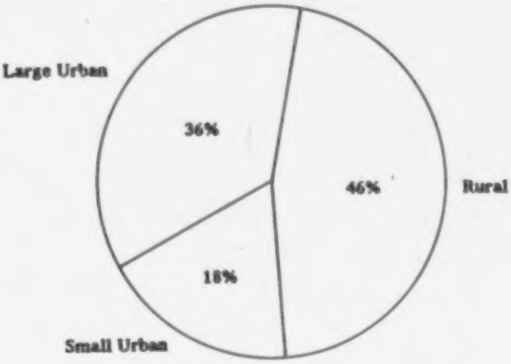
Figure 4 shows the percentage of small or rural hospitals and beds classified by ownership in 1986.

In 1986, 1,798, or 49 percent, of small or rural hospitals and 55 percent of small or rural statistical staffed beds, were owned and operated by private, nonprofit entities. These percentages are unchanged from 1984. Private nonprofit hospitals are typically run by a board of trustees and have 501(c)(3) tax status, meaning that they are exempt from federal tax requirements and use net revenue for renovation and modernization of plant and equipment and future operating costs.

State or local government bodies, agencies, or departments owned and operated 1,274, or 35 percent, of all small or rural hospitals and 29 percent of small or rural statistical staffed beds in 1986. These figures are down from 1,345, 37 percent, and 31 percent, respectively, in 1984. The decline reflects hospital closures, as well as government sales of these hospitals to private nonprofit or investor-owned multihospital systems.

The number of investor-owned small or rural hospitals rose from 538 to 584 between 1984 and 1986. In 1986, 16 percent of small or rural hospitals and statistical staffed beds were investor-owned.

Figure 1. Percentage of Rural and Urban Registered Community Hospitals, 1986



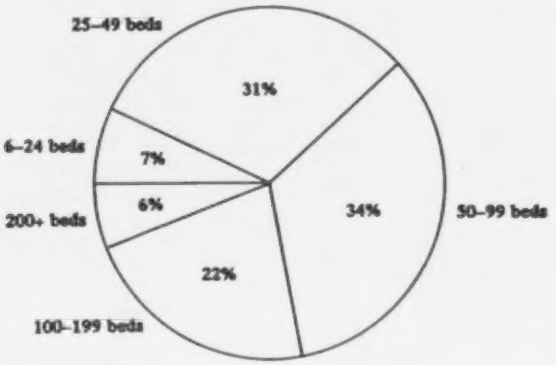
Number of Hospitals

	1986		1984	Percentage Change 1984–1986
Total U.S. hospitals	5,678	100%	5,759	-1.4%
Total rural hospitals	2,638	46%	2,696	-2.2%
Total small urban hospitals	1,018	18%	974	4.5%
Total urban hospitals	3,040	54%	3,063	-0.8%
Total small or rural hospitals	3,656	64%	3,670	-0.4%

Although the number of total U.S. community hospitals, rural hospitals, and urban hospitals decreased between 1984 and 1986, the number of small urban hospitals increased 4.5 percent—most likely a result of declining hospital admissions.

Source: American Hospital Association, Annual Survey of Hospitals, 1986

Figure 2. Percentage of Rural Registered Community Hospitals by Bed Size, 1986



Number of Hospitals

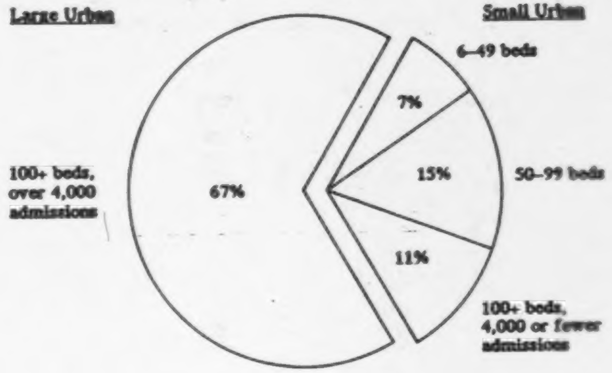
	1986	1984	Percentage Change 1984–1986
Rural	2,638	2,696	–2.2%
6–24 beds	175	182	–3.8%
25–49 beds	809	799	1.3%
50–99 beds	908	932	–2.6%
100–199 beds	576	606	–5.0%
200+ beds	170	177	–4.0%

In 1986, there were 2,638 rural hospitals. More than two–thirds of these hospitals had fewer than 100 beds. In many cases, these rural hospitals with more than 200 beds serve as rural referral centers and may offer a more extensive range of services.

The total number of rural hospitals dropped two percent since 1984; most of these were hospitals with 100 or more beds. During this same period, there was a slight increase in the number of hospitals with 25 to 49 beds.

Source: American Hospital Association, Annual Survey of Hospitals, 1986

Figure 3. Percentage of Urban Registered Community Hospitals by Bed Size, 1986



Number of Hospitals

Total urban	3,040	6–24 beds	36
Small urban	1,018	25–49 beds	184
Large urban	2,022	50–99 beds	468
		100+ beds, 4,000 or fewer admissions	330

In 1986, 1,018 hospitals were categorized as small urban representing 33 percent of total urban hospitals: 688 small urban hospitals had fewer than 100 beds; and 330 hospitals had 100 or more beds, but 4,000 or fewer admissions per year. The number of these 100+ bed urban hospitals with fewer than 4,000 admissions increased 19 percent since 1984, probably reflecting declines in admissions at U.S. hospitals.

Source: American Hospital Association, Annual Survey of Hospitals, 1986

Table 1. Statistical Staffed Beds by Bed Size, Small or Rural Registered Community Hospitals, 1984 and 1986

	Percentage of Total Small or Rural Beds	
	1984	1986
SMALL OR RURAL COMMUNITY HOSPITALS	100%	100%
Private Nonprofit	55%	55%
Investor-Owned	14%	16%
State and Local Government	31%	29%
BED SIZE		
Rural Hospitals	74%	72%
6–24 Beds	1%	1%
25–49	9%	10%
50–99	21%	21%
100–199	27%	25%
200 or more	16%	15%
Small Urban Hospitals	26%	28%
6–24 Beds	0.2%	0.2%
25–49	2%	2%
50–99	11%	11%
100+ with 4,000 or fewer admissions	13%	15%

Percentages may not add to exactly 100% due to rounding.

Source: American Hospital Association, Annual Survey of Hospitals, 1984 and 1986 data.

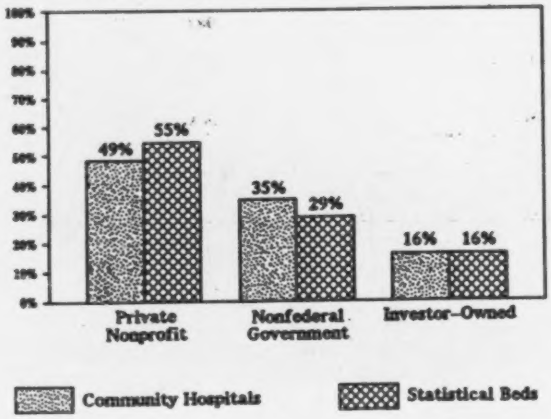
Geographic Distribution

The distribution of small or rural hospitals and beds across and within census regions is shown in figures 5 and 6. The distribution is essentially the same as in 1984.

Small or rural hospitals account for more than 50 percent of total hospitals in eight of the nine U.S. census regions. Small or rural hospitals are especially concentrated in the west north central region, where 85 percent of hospitals are small or rural. Because most rural hospitals have fewer than 100 beds, the concentration of small or rural statistical staffed beds within each region is much lower than the concentration of small or rural hospitals.

In those parts of rural America that consist of large, remote areas with low population density, access to care becomes a critical issue. When distance or weather make access to health care difficult, the need for small, easily accessible local hospitals is apparent.

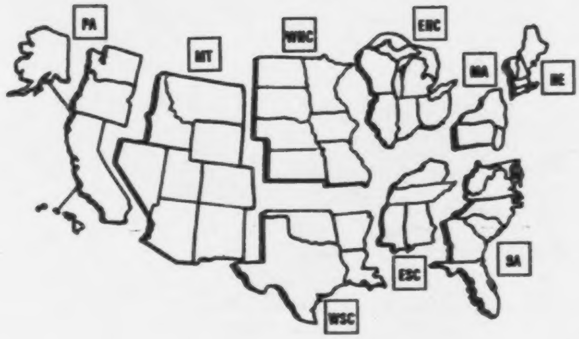
Figure 4. Percentage of Small or Rural Hospitals and Beds by Ownership, 1986



	Hospitals	Statistical Beds
Total small or rural	3,656	312,688
Private nonprofit	1,798	170,566
Government	1,274	91,551
Investor-owned	584	50,571

Source: American Hospital Association, Annual Survey of Hospitals, 1986

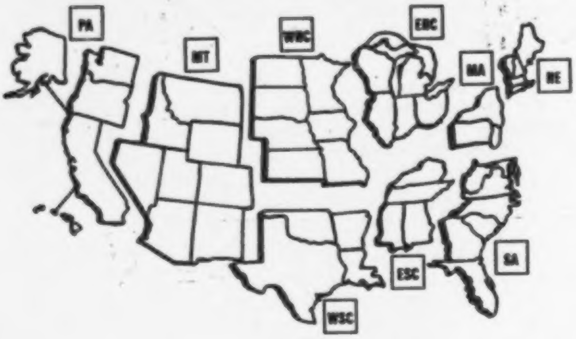
Figure 5. Distribution of Small or Rural Registered Community Hospitals and Beds by Census Region, 1986



	% Hospitals	% Beds
New England (NE)	4%	4%
Middle Atlantic (MA)	5%	8%
South Atlantic (SA)	14%	17%
East North Central (ENC)	13%	16%
East South Central (ESC)	10%	11%
West North Central (WNC)	18%	15%
West South Central (WSC)	17%	13%
Mountain (MT)	8%	6%
Pacific (PA)	11%	10%

Source: American Hospital Association, Annual Survey of Hospitals, 1986

Figure 6. Concentration of Small or Rural Registered Community Hospitals and Beds within Each Census Region, 1986



	% Hospitals	% Beds
New England (NE)	52%	26%
Middle Atlantic (MA)	34%	15%
South Atlantic (SA)	61%	33%
East North Central (ENC)	57%	27%
East South Central (ESC)	77%	48%
West North Central (WNC)	85%	51%
West South Central (WSC)	74%	39%
Mountain (MT)	78%	44%
Pacific (PA)	58%	28%

Source: American Hospital Association, Annual Survey of Hospitals, 1986

Closures

Since 1983, the number of community hospital closures has been increasing, with an especially large jump in 1986, when 71 hospitals closed. In each year between 1983 and 1986, most of the hospitals that closed were either rural hospitals or urban hospitals with fewer than 100 beds (figure 7).

Some of these reported hospital closures may actually represent mergers or hospital conversions to ambulatory care centers or nursing homes. However, it is apparent that growing competitive and financial pressures are forcing more small or rural hospitals to close. If closures continue to increase as they did in 1986, rural residents may face serious problems in finding health care services, particularly in remote rural areas.

Utilization

Changes in payment systems and consumer attitudes toward health and hospital care, along with advances in ambulatory care and changes in medical practice, have led to falling inpatient volume and increased outpatient volume at hospitals in recent years.

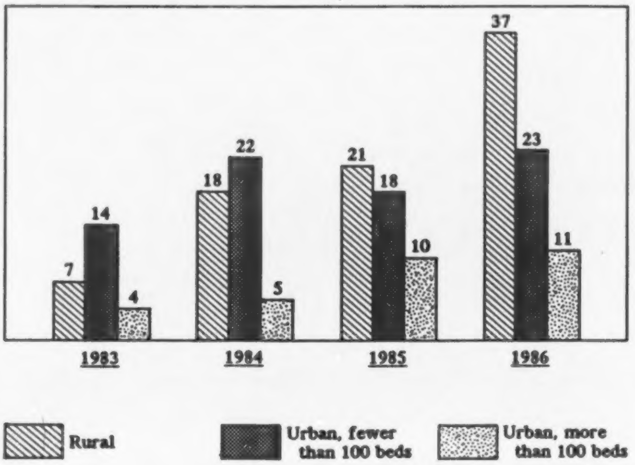
Admissions started falling earlier and have fallen faster at rural and small urban hospitals than at larger urban hospitals (table 2). Between 1984 and 1986, the number of admissions to all U.S. registered community hospitals fell by 8 percent, while admissions to small or rural hospitals fell by 11 percent. Urban hospitals of 6 to 24 beds saw the largest drop in admissions (25 percent) over the two-year period, with a 22 percent decline during 1984–85.

Although it had been declining for years, the average length of stay at small or rural hospitals rose from 7.0 to 7.2 days between 1984 and 1986, a gain of 3 percent. During the two-year period, small urban hospitals of 6 to 24 beds saw the largest increase in length-of-stay (13 percent). Average length of stay declined for other categories of small urban hospitals. Table 3 shows average lengths of stay in 1986 by region.

The increase in small or rural hospital average length of stay may be attributed to the shift of less severely ill patients to appropriate non-inpatient acute care settings. As hospitals increasingly treat less severely ill patients on an outpatient basis, inpatients tend to be those patients requiring more intensive and costly care and longer stays.

Average daily census, which measures the average use of hospital inpatient capacity per day, is an important indicator of the demand for inpatient services as well as a monitor of revenue, expenses, and productivity related to the provision of inpatient services. From 1980 through 1984, when small or rural hospitals were experiencing sharp drops in admissions, the average daily census for small or rural hospitals declined at a rate more than twice the average for total U.S. community hospitals (table 4). Since 1984, however, the average daily census at small or rural hospitals has declined at about the same rate in all U.S. community hospitals. This largely reflects the onset of admission declines at larger urban hospitals after 1983.

Figure 7. Community Hospital Closures



Hospitals with 4,000 or fewer annual admissions could not be broken out for this analysis.

Source: American Hospital Association, 1987

Table 2. Admissions, Registered Community Hospitals, 1980–1986

	Total Inpatient Admissions	Percentage change over period		
	1986	1980–1984	1984–1985	1985–1986
TOTAL U.S. HOSPITALS	32,378,796	–3%	–5%	–3%
SMALL OR RURAL HOSPITALS	8,558,318	–14%	–6%	–5%
BED SIZE				
Rural Hospitals	6,360,128	–18%	–8%	–7%
6–24 Beds	78,619	–25%	–13%	–7%
25–49	778,021	–9%	–8%	–5%
50–99	1,727,368	–18%	–10%	–6%
100–199	2,305,230	–13%	–7%	–10%
200 or more	1,470,890	–27%	–10%	–5%
Small Urban Hospitals	2,198,190	+3%	+1%	–1%
6–24 Beds	17,083	–23%	–22%	–3%
25–49	199,488	–23%	–10%	+3%
50–99	1,054,756	–2%	–6%	–6%
100+ with 4,000 or fewer admissions	926,863	+27%	+17%	+6%

Note: The increases at urban hospitals with more than 100 beds but fewer than 4,000 admissions largely reflect increases in the number of hospitals in this category.

Source: American Hospital Association, Annual Survey of Hospitals, annual data.

Table 3. Average Length of Stay, Registered Community Hospitals, 1986

	Superdivisions				All Regions
	North East	North Central	South	West	
TOTAL U.S. HOSPITALS	8.0	7.4	6.7	6.2	7.1
SMALL OR RURAL HOSPITALS	8.2	8.1	6.5	6.8	7.2
BED SIZE					
Rural Hospitals	7.8	8.0	6.4	6.6	7.1
6–24	4.8	5.3	4.4	5.4	5.0
25–49	6.0	5.9	4.9	5.8	5.5
50–99	7.3	8.4	5.9	7.2	7.0
100–199	7.7	8.6	6.9	6.1	7.4
200 or more	8.5	7.9	7.0	8.4	7.5
Small Urban Hospitals	9.0	8.5	6.7	7.0	7.5
6–24	5.4	6.6	4.6	3.7	4.5
25–49	5.9	5.3	5.5	5.1	5.4
50–99	7.5	6.4	5.9	5.3	6.1
100+ with 4,000 or fewer admissions	11.6	11.6	7.7	10.1	9.6

Source: American Hospital Association, Annual Survey of Hospitals, 1986.

Table 4. Average Daily Census, Registered Community Hospitals, 1984–1986

	Average Daily Census	Percentage change over period		
	1986	1980–1984	1984–1985	1985–1986
TOTAL U.S. HOSPITALS	111	–4.7%	–7.4%	–1.8%
SMALL OR RURAL HOSPITALS	46	–10.5%	–7.8%	–2.1%
BED SIZE				
Rural Hospitals	47	–13.3%	–7.7%	–2.1%
6–24 Beds	6	–22.2%	0.0%	–14.3%
25–49	14	–15.8%	–6.3%	–6.7%
50–99	37	–10.9%	–9.8%	0.0%
100–199	81	–9.2%	–6.7%	–2.4%
200 or more	179	–8.8%	–7.1%	–1.6%
Small Urban Hospitals	44	+2.1%	–4.2%	–4.3%
6–24 Beds	6	–11.1%	–12.5%	–14.3%
25–49	16	–19.0%	–5.9%	0.0%
50–99	38	–12.5%	–7.1%	–2.6%
100+ with 4,000 or fewer admissions	72	+2.4%	–6.0%	–8.9%

Source: American Hospital Association, Annual Survey of Hospitals, 1986.

More and more, small or rural community hospitals are offering new ambulatory and nonacute care services, including ambulatory surgery, home health care, and health promotion. As a result, outpatient utilization at small or rural hospitals has grown rapidly. Outpatient visits at small or rural hospitals rose 6 percent in 1985 and 11 percent in 1986 (table 5). Also, in 1986, 43 percent of surgical operations performed at small or rural hospitals were done on an outpatient basis. Corresponding to the increase in outpatient services, the share of small or rural hospitals' income derived from outpatient care reached 21 percent of gross patient revenues in 1986.

In addition, more small or rural hospitals are maintaining swing beds, skilled nursing, or other long-term care units. In 1986, of the 8.6 million admissions to small or rural community hospitals, nearly 40,000 were for nonacute care in swing-bed programs. According to the Health Care Financing Administration, 945 hospitals operated swing-bed programs as of December 1987. Recent federal legislative actions have opened the swing-bed program to more rural hospitals by raising the maximum number of beds for participation from 50 to 100, effective April 1, 1988.

Table 5. Outpatient Visit Trends, Registered Community Hospitals, 1984–1986

	Percentage change over period	
	1984–1985	1985–1986
TOTAL U.S. HOSPITALS	+3%	+6%
SMALL OR RURAL HOSPITALS	+6%	+11%
BED SIZE		
Rural Hospitals	+3%	+8%
6–24 Beds	+9%	+5%
25–49	+10%	+13%
50–99	+4%	+9%
100–199	+4%	+7%
200 or more	–5%	+6%
Small Urban Hospitals	+16%	+18%
6–24 Beds	–34%	+21%
25–49	+6%	+43%
50–99	+5%	+9%
100+ with 4,000 or fewer admissions	+38%	+24%

Note: The increases at urban hospitals with more than 100 beds but fewer than 4,000 admissions largely reflect increases in the number of hospitals in this category.

Source: American Hospital Association, Annual Survey of Hospitals, 1984–1986.

Staffing and Beds

Between 1980 and 1987, small or rural hospitals reduced their staffs in order to maintain efficient operations and increase productivity. Recently, however, the rate of personnel reductions has slowed in response to a rapid increase in outpatient visits, a slowing in the rate of admission declines, and an increase in the average severity of illness of admitted patients. Between 1980 and 1984, the number of full-time equivalent employees (FTEs) on small or rural community hospital payrolls dropped by 7 percent (table 6). Since 1984, most bed-size categories of small or rural hospitals have seen an increase in FTEs.

Some hospitals, especially those having between 50 and 100 beds, have attempted to adapt to volume fluctuations through increased use of part-time employees. In some instances, reductions in full-time staffs may represent shifts to part-time status, possibly involving increased employee benefits to offset the loss in wages. In 1986, the proportion of total personnel designated as part-time at small or rural hospitals generally exceeded the U.S. hospital average (figure 8). For rural hospitals, the smaller the hospital, the greater the proportion of part-time employees.

Table 6. Full-Time Equivalent Employees, Registered Community Hospitals, 1980–1986

	Full-Time Equivalent Employees	Percentage change over period		
	1986	1980–1984	1984–1985	1985–1986
TOTAL U.S. HOSPITALS	3,024,853	+5%	-1%	+1%
SMALL OR RURAL HOSPITALS	700,229	-7%	+1%	+1%
BED SIZE				
Rural Hospitals	493,288	-12%	-2%	-0.4%
6–24 Beds	6,829	-17%	+3%	+0.2%
25–49	57,853	0%	+1%	+3%
50–99	131,417	-10%	-3%	+0.4%
100–199	174,083	-6%	-1%	-4%
200 or more	123,106	-23%	-5%	+3%
Small Urban Hospitals	206,941	+10%	+9%	+4%
6–24 Beds	1,637	-23%	-7%	+22%
25–49	19,290	-16%	+3%	+10%
50–99	89,295	+9%	+1%	-2%
100+ with 4,000 or fewer admissions	96,719	+21%	+21%	+9%

Note: The increases at urban hospitals with more than 100 beds but fewer than 4,000 admissions largely reflect increases in the number of hospitals in this category.

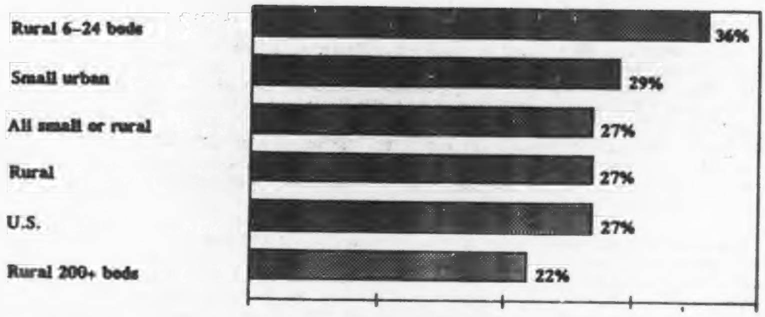
Source: American Hospital Association, Annual Survey of Hospitals, annual data.

Figure 8. Percentage of Part-Time Personnel, Selected Categories of Registered Community Hospitals, 1986

Total U.S. hospitals	27%
Total small or rural hospitals	27%

Bed Size

Rural	27%	Urban	29%
6–24	36%	6–24	29%
25–49	29%	25–49	28%
50–99	29%	50–99	31%
100–199	27%	100+, 4,000 or fewer admissions	28%
200 or more	22%		



In 1986, 27 percent of total small or rural hospital personnel were part–time employees. The percentage was highest among the smallest rural hospitals (those having 6 to 24 beds) where, on average, 36 percent of employees worked part–time.

The percentage of part–time personnel is calculated by dividing the number of part–time personnel by the sum of part–time and full–time personnel. Percentages reported in the Profile of Small or Rural Hospitals, 1980–1984 were calculated using a different formula, and represented part–time employees as a percentage of full–time employees.

Source: American Hospital Association, Annual Survey of Hospitals, 1986

Rural hospitals, particularly those located in remote areas, have long experienced problems in recruiting and retaining professional personnel. As a result, these hospitals often train personnel to perform functions in addition to their primary responsibilities. For example, laboratory and x–ray personnel or business office and admitting personnel might have interchangeable roles. Such cross–training of personnel can help to ensure the efficient and cost–effective operation of a hospital.

Hospitals have also taken a number of beds out of service as the number of inpatients has fallen (table 7). Between 1980 and 1986, the number of statistical staffed beds at rural hospitals dropped 11 percent. The decline in beds was not as sharp at small urban hospitals. This in part reflects offsetting increases in the number of urban hospitals now qualifying as small, largely because they have experienced drops in admissions to 4,000 or fewer.

Table 7. Statistical Staffed Beds, Registered Community Hospitals, 1980–1986

	Percentage change over period		
	1980–1984	1984–1985	1985–1986
TOTAL U.S. HOSPITALS	+3%	–2%	–2%
SMALL OR RURAL HOSPITALS	–2%	+1%	–2%
BED SIZE			
Rural Hospitals	–7%	–2%	–2%
6–24 Beds	–14%	–1%	0%
25–49	+1%	+1%	+2%
50–99	–6%	–2%	–1%
100–199	0%	+1%	–6%
200 or more	–20%	–6%	–1%
Small Urban Hospitals	+17%	+8%	+0.2%
6–24 Beds	–27%	–11%	+16%
25–49	–11%	–3%	+4%
50–99	+5%	+1%	–3%
100+ with 4,000 or fewer admissions	+40%	+18%	+2%

Note: The increases at urban hospitals with more than 100 beds but fewer than 4,000 admissions largely reflect increases in the number of hospitals in this category.

Source: American Hospital Association, Annual Survey of Hospitals, annual data.

Payer Mix

Compared with total U.S. community hospitals, small or rural hospitals tend to receive a greater share of their revenues from Medicare and Medicaid and a smaller share from nongovernment sources (table 8).

In 1986, 47 percent of all U.S. community hospitals reported that Medicare accounted for 43 percent or more of net patient revenue; 58 percent of small or rural hospitals did so. Among those hospitals having between 50 and 99 beds, nearly three-fourths reported proportions of Medicare revenue of 43 percent or more, and 77 percent of rural hospitals having between 25 and 49 beds did so. Generally, the proportion of Medicare revenue at small or rural hospitals has increased since 1984. The greater dependence on Medicare revenue at rural hospitals reflects the higher concentrations of elderly residents in rural areas.

Medicaid represented 9 percent or more of net patient revenue at 53 percent of U.S. community hospitals in 1986. A greater percentage of small or rural hospitals reports proportions of Medicaid revenue this high. Medicaid accounted for 9 percent or more of net patient revenues at 57 percent of small or rural hospitals, and at 71 percent of rural hospitals in the 25 to 49 bed-size group. In general, small or rural hospitals have experienced increases in the proportion of revenue they receive from Medicaid since 1984.

Small or rural hospitals serve a high volume of uninsured patients. The incidence of poverty is greater in rural areas than in urban areas. Moreover, the rural poor are more likely than the urban poor to be employed or to be members of intact families with at least one employed family member. As a result, the rural poor often do not qualify for Medicaid, which favors single mothers and their children and the unemployed. Nor can these poor residents afford to purchase private health care coverage. These problems are reflected in hospitals' uncompensated care burdens. In 1986, uncompensated care represented 6 percent of gross patient revenues at small or rural hospitals.

Nongovernment sources of revenue accounted for at least half of net patient revenues at 49 percent of all U.S. community hospitals, but at only 38 percent of small or rural hospitals. However, more than two-thirds of small or rural hospitals in two bed-size categories reported nongovernment revenue proportions of 50 percent or more. In 1986, nongovernment revenues were at least half of patient revenues at 68 percent of rural hospitals with 100 to 199 beds, and at 72 percent of urban hospitals with 100 or more beds. The reasons for these high percentages, which are up substantially from 1984 figures, are unclear.

Table 8. Distribution of Hospitals by Percentage of Medicare, Medicaid, and Other Net Patient Revenue, Registered Community Hospitals, 1986

	Number of Hospitals*	Percentage of Medicare Net Revenue		
		0–42%	43–52%	53+%
TOTAL U.S. HOSPITALS	5,676	53%	38%	9%
SMALL OR RURAL HOSPITALS	3,654	42%	48%	10%
BED SIZE				
Rural Hospitals	2,638	41%	48%	11%
6–24	175	75%	12%	13%
25–49	809	23%	61%	16%
50–99	908	26%	64%	10%
100–199	576	74%	21%	6%
200 or more	170	67%	31%	3%
Small Urban Hospitals	1,016	45%	45%	10%
6–24	36	50%	42%	8%
25–49	183	39%	51%	10%
50–99	467	26%	65%	9%
100+ with 4,000 or fewer admissions	330	74%	15%	11%

Percentages may not add to exactly 100% due to rounding.

* Two hospitals did not provide sufficient data on the 1986 Annual Survey to calculate or estimate percentages of revenue from various payers.

Source: American Hospital Association, Annual Survey of Hospitals, 1986.

Table 8 (Continued)

Percentage of Medicaid Net Revenue			Percentage of Total Nongovernment Net Revenue**		
0–8%	9–14%	15+%	0–49%	50–60%	61+%
47%	43%	10%	52%	39%	10%
42%	49%	9%	63%	30%	8%
38%	52%	9%	65%	29%	6%
48%	46%	6%	62%	29%	9%
29%	66%	5%	77%	17%	6%
39%	50%	11%	78%	17%	5%
45%	44%	11%	32%	60%	8%
48%	38%	15%	54%	41%	5%
50%	41%	9%	56%	32%	12%
47%	50%	3%	64%	28%	8%
30%	65%	6%	61%	25%	14%
55%	38%	8%	73%	14%	13%
55%	32%	13%	28%	63%	9%

** Nongovernment net revenue includes self-pay, Blue Cross, commercial insurance, and other nongovernmental sources of revenue.

Net Patient Margins

Payments to hospitals per patient have not kept pace with increases in hospital costs per patient. Consequently, aggregate net patient revenue margins have declined since 1984 in all but two bed-size categories of small or rural hospitals (rural hospitals with 200 or more beds and urban hospitals with fewer than 25 beds) as well as at the national level (table 9). More than half of hospitals in all categories of small or rural hospitals except rural hospitals with 100 or more beds report that their net patient margins are negative--that is, they are losing money on patient care. Among rural hospitals with fewer than 50 beds, 73 percent report deficits and nearly 60 percent report deficits of 6 percent or greater (table 10).

Declining and negative revenue margins arise from payments that are often inadequate, hospital difficulties in covering fixed costs when inpatient use falls sharply, and rising levels of uncompensated care.

Although some hospitals are able to offset negative patient margins with tax appropriations or nonoperating revenue such as grants or philanthropic contributions, this is not always the case. Many hospitals report financial deficits even after adding revenue from other sources.

Table 9. Net Patient Margin, Registered Community Hospitals, 1984 and 1986

	1984	1986
TOTAL U.S. HOSPITALS	-1.7%	-2.0%
URBAN HOSPITALS	-1.8%	-2.0%
SMALL OR RURAL HOSPITALS	-1.1%	-2.2%
BED SIZE		
Rural Hospitals	-0.9%	-1.5%
6–24	-13.8%	-20.7%
25–49	-6.5%	-8.6%
50–99	-1.9%	-2.9%
100–199	+0.5%	+0.3%
200 or more	+0.8%	+0.9%
Small Urban Hospitals	-1.6%	-3.4%
6–24	-14.6%	-6.6%
25–49	-11.2%	-14.8%
50–99	+0.1%	-2.0%
100+ with 4,000 or fewer admissions	-1.9%	-2.8%

Source: American Hospital Association, Annual Survey of Hospitals, annual data.

Table 10. Distribution of Net Patient Margin by Urban/Rural Bed Size, Registered Community Hospitals, 1986

	6%+ Deficit	3.0–5.9% Deficit	0.1–2.9% Deficit	0.0–2.9% Profit	3.0–5.9% Profit	6%+ Profit
TOTAL U.S. HOSPITALS	29%	12%	12%	19%	14%	14%
SMALL OR RURAL HOSPITALS	37%	13%	12%	16%	11%	11%
Rural Hospitals	38%	13%	12%	16%	12%	10%
Under 50 beds	57%	9%	7%	9%	10%	8%
50–99 beds	36%	15%	15%	17%	10%	8%
100 or more beds	18%	15%	14%	23%	16%	15%
URBAN HOSPITALS	22%	11%	13%	21%	15%	18%
Small Urban Hospitals	34%	12%	13%	18%	10%	14%
Under 50 beds	48%	10%	11%	14%	5%	13%
50–99 beds	29%	10%	15%	21%	12%	14%
100+ beds with 4,000 or fewer admissions	33%	16%	12%	15%	11%	13%

Percentages may not add to exactly 100% due to rounding.

Source: American Hospital Association, Annual Survey of Hospitals, 1986.

CONCLUSION

Information included in this profile is grouped according to bed size, region, and urban or rural location. However, when evaluating an individual hospital, it is necessary to take local conditions, variations, and trends into account. Ongoing analysis should determine whether local patterns of utilization, costs of labor and supplies, inflationary pressures, and third-party reimbursement parallel those of hospitals nationwide. Variations will affect management responses to current and future health care issues such as changes in public and private-sector financing or payment systems, further declines in inpatient utilization, increases in the use of outpatient and nonacute care services, and growing competition among health care providers.

The mission of the small or rural hospital continues to be service to its community. At the same time, small or rural hospitals are challenged to significantly change their operations in response to their environment. Many hospitals are already meeting this challenge successfully, and more are realizing the need to do so. The need for well-qualified board members and CEOs is apparent, for those who govern and manage rural hospitals will play a leadership role in major organizational changes and in ensuring continuing community support.

APPENDIX A

Data Characteristics and Assumptions

This profile contains data for all small or rural hospitals voluntarily responding to the AHA Annual Survey of Hospitals in 1980 through 1986. If a hospital did not report for all six years, standard estimates were used. Although the use of estimates for missing data means the data are not necessarily comparable for individual hospitals for all six years, results aggregated at the national level by ownership, bed size, and census division are not compromised by this approach.

Net patient margin data in table 10 are based on 79 percent of U.S. community hospitals and 76 percent of small or rural community hospitals reporting sufficient data to calculate net patient margins. Although the tables accurately portray revenue distributions and margin variation within the samples, conclusions cannot be generalized to the universe without considering the performance of hospitals that did not provide revenue and margin data.

Urban and rural bed-size categories were selected to present the data concisely and still highlight differences between smaller and larger hospitals. The small urban hospitals with more than 100 beds were analyzed as a single group, in contrast to rural hospitals, which were analyzed in two groups, 100–199 and 200+ beds. It was necessary to place all small urban hospitals in one group to appropriately portray statistically the percentage changes from one year to another for the small number (25) of urban hospitals with more than 200 beds but with 4,000 or fewer admissions per year.

The level of hospital operating margins as reported in the annual survey may differ from margins reported in other sources, such as the AHA National Hospital Panel Survey. Reasons for this include differences in sample size and composition, differences in reporting periods covered by the two surveys, the estimation process used in the panel survey, and the items missing in the annual survey. However, the trend in margin experience is the same for both sources: hospital net patient margins initially increased, then decreased, during the six-year period. To describe the characteristics of small or rural hospitals, as this profile does, the annual survey represents the most current and comprehensive data source available.

APPENDIX B

Glossary

Adjusted Expense per Admission	Average expense to the hospital in providing care for one inpatient stay. Total expenses are adjusted to reflect only the costs of caring for inpatients, by multiplying total expenses by the ratio of inpatient revenue to total patient revenue. This adjusted expense figure is divided by total admissions to derive the average expense per hospital stay.
Admission	Formal acceptance by a hospital of a patient who is to receive health care services while lodged in an area of the hospital reserved for continuous nursing services.
Census, Average Daily	Average number of inpatients, excluding newborns, receiving care each day during a reporting period.
Census Regions (established by U.S. Bureau of the Census)	New England Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont South Atlantic Delaware District of Columbia Florida Georgia Maryland North Carolina South Carolina Virginia West Virginia East South Central Alabama Kentucky Mississippi Tennessee West South Central Arkansas Louisiana Oklahoma Texas Pacific Alaska California Hawaii Oregon Washington Middle Atlantic New Jersey New York Pennsylvania East North Central Illinois Indiana Michigan Ohio Wisconsin West North Central Iowa Kansas Minnesota Missouri Nebraska North Dakota South Dakota Mountain Arizona Colorado Idaho Montana Nevada New Mexico Utah Wyoming
Discharge, Inpatient	Formal release by a hospital, upon a physician's direction or through death of a patient, of a patient who no longer requires hospital care; in addition, Medicare's prospective pricing system includes the transfer of a patient to another hospital or unit that is excluded from the prospective pricing system.
Full-Time Equivalent (FTE)	A number, based on the number of persons on the hospital's payroll as of September 30 of the reporting period, calculated by adding the number of full-time personnel to one-half the number of part-time personnel, excluding medical and dental residents and interns and other trainees.
Health Care Coalition	A voluntary alliance of discrete interests sharing the principal objective of improving health care cost effectiveness within a community.

Health Maintenance Organization (HMO)	An organization that has management responsibility for providing comprehensive health care services on a prepayment basis to voluntarily enrolled persons within a designated population.
Hospital, Community	A hospital, usually short-term general nonfederal, whose services are available for use primarily by residents of the community in which it is located.
Hospital, Investor-Owned	A hospital that is owned and operated by a corporation or an individual, and that operates on a for-profit basis.
Hospital, Nonfederal Government	A hospital that is managed by an agency or department of a state or local government.
Hospital, Private Nonprofit	A hospital that operates on a not-for-profit basis under the ownership and control of a legal entity other than a government agency.
Hospital, Registered	A hospital recognized by the American Hospital Association as having the essential specific characteristics of a hospital.
Hospital, Rural	A registered general hospital that is located outside a metropolitan statistical area.
Hospital, Small or Rural	A health care institution that has fewer than 100 acute care beds, an acute care hospital located outside a metropolitan statistical area (may have more than 100 beds), or a hospital having 4,000 or fewer annual admissions.
Hospital, Small Urban	A registered general hospital that is located within a metropolitan statistical area and that has fewer than 100 beds or 4,000 or fewer annual admissions.
Length of Stay, Average	The average length of stay of all or a class of inpatients discharged over a given period; derived by dividing the number of discharge days by the number of discharges.
Margin, Net Patient	The percentage of revenue from patient care retained after expenses and deductions, calculated as net patient revenue less total expenses divided by net patient revenue, times 100 percent.
Medicare Net Revenue	Revenue, less contractual allowances, bad debt, and charity care, from the federal program created by Title XVIII—Health Insurance for the Aged, a 1965 amendment to the Social Security Act, that provides health insurance benefits primarily to persons over the age of 65 and others eligible for Social Security benefits.
Metropolitan Statistical Area	A geographical designation, usually defined as an entire county or group of counties, that represents an integrated social and economic unit and that contains either a city of at least 50,000 population or an urban area of at least 50,000 with a total metropolitan population of at least 100,000.
Outpatient Visit	All services provided a patient who is not lodged in the hospital in the course of a single appearance in an outpatient or inpatient unit.
Part-Time Personnel	The number of persons on the hospital payroll, as of September 30 of the reporting period, whose regularly scheduled work week is less than 35 hours (excludes medical and dental residents, interns, and other trainees).
Preferred Provider Organization (PPO)	A term applied to a variety of direct contractual relationships between hospitals, physicians, insurers, employers, or third-party administrators, where providers negotiate with group purchasers to provide health services for a defined population. PPOs typically share three characteristics: (1) a negotiated system of payment of services that may include discounts from usual charges or ceilings imposed on a charge, per diem, or per discharge basis; (2) financial incentives for individual subscribers (insured) to use contracting providers, usually in the form of reduced copayment and deductibles, broader coverage of services, or simplified claims processing; and (3) an extensive utilization review program.

Revenue, Net Patient	Gross revenue from services to inpatients and outpatients, minus government and nongovernment contractual adjustments, bad debts, charity, and other deductions.
Revenue, Outpatient	Gross revenues from services to outpatients.
Revenue, Total Net	Net patient revenue plus all other operating revenue such as tax appropriations, and nonoperating revenue such as contributions, endowment revenue, government grants, interest income, and sale of assets.
Statistical Staffed Beds	The average number of beds, cribs, and pediatric bassinets set up and staffed for use for inpatients during the reporting period; derived by adding the total number of beds available each day during the hospital's reporting period and dividing this figure by the total days in the reporting period.
Superdivisions	Northeast Connecticut Maine Massachusetts New Hampshire New Jersey New York Pennsylvania Rhode Island Vermont South Alabama Arkansas Delaware District of Columbia Florida Georgia Kentucky Louisiana Maryland Mississippi North Carolina Oklahoma South Carolina Tennessee Texas Virginia West Virginia North Central Illinois Indiana Iowa Kansas Michigan Minnesota Nebraska North Dakota Ohio South Dakota Wisconsin West Arizona Alaska California Colorado Hawaii Idaho Montana Nevada New Mexico Oregon Utah Washington Wyoming
Swing Bed	A hospital bed regularly maintained for both short-term and long-term use depending on need.
Uncompensated Care	The sum of bad debts and charity care absorbed by a hospital in providing medical care for patients who are uninsured or unable to pay.

APPENDIX 4.—QUESTIONS AND ANSWERS OF WITNESSES

Item 1

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

July 20, 1988

Sandral Hullett-Robertson, M.D.
Director of Health Services
West Alabama Health Services, Inc.
P.O. Box 711
Eutaw, Alabama 35462

Dear Dr. Hullett-Robertson:

On behalf of myself and the other members of the Senate Special Committee on Aging, I would like to thank you for participating in the July 11 hearing on the "Rural Health Care Challenge: Part 2: Rural Health Care Personnel." We appreciated receiving your excellent testimony, which I believe will enhance our efforts, as well as those of others active in this area who review the hearing record, to effectively address the shortages of health care personnel in medically underserved rural communities.

Due to time constraints, Senator Reid and I were unable to ask a number of questions that we believe are necessary for completing the hearing record. Therefore, we would very much appreciate your providing timely written responses to the questions listed below.

1. In your testimony you mentioned malpractice insurance causing general practitioners to drop their obstetrical services in your area. This seems to be a problem plaguing the nation's rural areas. Would you please comment further on the effects you see of the rapid decline in availability of obstetrical services in your area?

2. Aside from the impact on the availability of obstetrical services, have mounting malpractice rates worsened physician shortages in your area?

We appreciate your taking the time to answer these questions and will, of course, forward you the final hearing print as soon as it is available. Should you have any questions regarding this request, please contact Christopher Jennings or Jenny McCarthy of the Committee staff at (202) 224-5364.

Thank you for your cooperation and assistance with this request. We look forward to reviewing your responses.

Sincerely,

John Melcher
Chairman

West Alabama Health Services inc.

James W. Coleman
EXECUTIVE DIRECTOR

Sandral Hullett, M.D., M.P.H.
HEALTH SERVICES DIRECTOR

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August 18, 1988

Ms. Annabelle Richardson
United States Senate
Special Committee on Aging
Washington, DC 20510-6400

Dear Ms. Richards:

Enclosed is the corrected manuscript of the hearing held July 11, 1988. Also, enclosed is the response to the two questions which were asked to be answered by me.

I appreciated having the opportunity to participate in the Senate hearings; and, please let me know if I can be of further assistance in the future.

Sincerely,

Sandral Hullett

Sandral Hullett, M.D.
Health Services Director

SH/cbr

Enclosures

The cost and regulations of medical malpractice insurance to cover family practitioners to participate in uncomplicated deliveries has forced many primary care providers in the West Alabama area to discontinue obstetrical services.

In Tuscaloosa County, the largest county and city in the area, no primary care providers are performing deliveries. The rural counties of West Alabama also have seen a steady decrease. In 1984, in Greene, Hale, and Sumter Counties a total of 15 doctors were present and 9 were delivering babies. Today, 1988, there is a total of 14 doctors with 4 delivering babies. The total number of deliveries last year in Greene and Hale Counties was 311.

In 1979, my malpractice insurance cost $500 annually. In 1981, I have been requested to pay the premimum of an obstetrician at $32,000/year. Interestingly, the number of deliveries I now perform have actually decreased; however, the premimum is higher.

My agency and the community are constantly looking for someone who will combine OB with a general practice; and, it is extremely difficult. Malpractice insurance crisis has definitely affected the WAHS area in decreasing the number of practicing physicians (some physicians who were almost ready to retire retired early), decreased the number of providers actually delivering services, and has increased the number of poor people seeking services.

Other problems which affect patient care in rural communites and this community as a result of the malpractice crisis are:

1. women are coming for prenatal care much later due to lack of providers; and
2. in some areas where infant mortality has improved, the problem again has reoccurred due to lack of assess of providers.

If some special provisions to decrease malpractice could be made for rural physicians who are providing the services, it would be appreciated.

Item 2

JOHN MELCHER, MONTANA, CHAIRMAN
JOHN GLENN, OHIO
LAWTON CHILES, FLORIDA
DAVID PRYOR, ARKANSAS
BILL BRADLEY, NEW JERSEY
QUENTIN N. BURDICK, NORTH DAKOTA
J. BENNETT JOHNSTON, LOUISIANA
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MAX I. RICHTMAN, STAFF DIRECTOR
G. LAWRENCE ATKINS, MINORITY STAFF DIRECTOR

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

July 20, 1988

James L. May
Executive Director
Northwest Health Services
502 State Street
Mound City, Missouri 64470

Dear Mr. May:

On behalf of myself and the other members of the Senate Special Committee on Aging, I would like to thank you for participating in the July 11 hearing on the "Rural Health Care Challenge: Part 2: Rural Health Care Personnel." We appreciated receiving your excellent testimony, which I believe will enhance our efforts, as well as those of others active in this area who review the hearing record, to effectively address the shortages of health care personnel in medically underserved communities.

Due to time constraints, I was unable to ask a number of questions that I believe are necessary for completing the hearing record. Therefore, I would very much appreciate your providing timely written responses to the questions listed below.

1. How do you respond to the basic Administration position that the physician shortage in medically underserved communities will be taken care of by laws of supply and demand, and that a significant recommitment of resources for the National Health Service Corps is not necessary because of the increasing number of physicians in this nation?
2. Many rural communities such as yours have a disproportionately high incidence of residents who are either uninsured or underinsured. While the Rural Health Clinic Act can play an important role in assuring needed medical services to Medicare recipients, what role do the rural health clinics in your area play in meeting the health care needs of those with little or no medical insurance?

We appreciate your taking the time to answer these questions and will, of course, forward you the final hearing print as soon as it is available. Should you have any questions regarding this request, please contact Christopher Jennings or Jennifer McCarthy of the Committee staff at (202) 224-5364.

Lastly, we are enclosing a copy of the draft paper on rural health care personnel issues that was prepared in conjunction with the July 11 hearing. When completed, the paper will be incorporated into a Committee report on the rural health care system to be released later this summer. In view of your knowledge of these issues, we would appreciate your reviewing the paper and sharing with us any comments or suggestions you might have as a result. To meet our publishing deadline, we would appreciate having the benefit of your views by early August.

Thank you for your cooperation and assistance with this request. We look forward to reviewing your responses.

Sincerely,

John Melcher
Chairman

The CLINIC
NORTHWEST HEALTH SERVICES INC
502 STATE STREET • MOUND CITY, MO 64470
(816) 442-5419

[illegible] SEP [illegible] 25

August 29, 1988

John Melcher
Chairman
United States Senate
Special Committee on Aging
Washington, D.C. 20510-6400

Dear Chairman Melcher:

With regard to your letter of July 20th, the following is my reply:

1) Response: I believe the Administration's position of relying on the basic economic law of supply and demand to provide an adequate supply of physicians for rural areas is preposterous. It is demonstrative of the Administration's lack of understanding of the health care system and the medical profession working within that health care system.

It presumes a comparable practice environment in rural and urban practices. That is a false presumption. Without major overhaul, rural practice settings will never be competitive with the urban practice setting and, therefore, not competitive for the supply of physicians. The rural practice environment must be reorganized from the solo independent practice environment to a group practice environment and the rural inequity of reimbursement must be eliminated in order for the law of supply and demand to solve the problem of rural shortage of physicians. It is extremely important for the re-commitment of resources for the National Health Service Corp, stimulation of the reorganization of the rural practice setting and elimination of the inequitable reimbursement for rural services if we are to save the rural health care system.

2) Response: It is my experience that the Rural Health Clinics Act, while assuring the recovery of the cost of providing services for the rural elderly and Medicaid patients, does very little if anything to relieve the problem of the low income patient with little or no insurance.

I appreciate the opportunity to participate in these hearings and sincerely hope that they may be of some effect in improving access to care for the rural geriatric patient.

Sincerely,

James L. May

James L. May
Executive Director

Item 3

JOHN MELCHER, MONTANA, CHAIRMAN

JOHN GLENN, OHIO
LAWTON CHILES, FLORIDA
DAVID PRYOR, ARKANSAS
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G. LAWRENCE ATKINS, MINORITY STAFF DIRECTOR

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

July 20, 1988

Pat Nessland, R.N.
Director of Nursing
Frances Mahon Deaconess Hospital
621 3rd Street South
Glasgow, Montana 59230

Dear Pat:

On behalf of myself and the other members of the Senate Special Committee on Aging, I would like to thank you for participating in the July 11 hearing on the "Rural Health Care Challenge: Part 2: Rural Health Care Personnel." We appreciated receiving your excellent testimony, which I believe will enhance our efforts, as well as those of others active in this area who review the hearing record, to effectively address the shortages of health care personnel in medically underserved communities.

Due to time constraints, Senators Reid, Grassley, and I were unable to ask a number of questions that we believe are necessary for completing the hearing record. Therefore, we would very much appreciate your providing timely written responses to the questions listed below.

1. With nurses in rural areas having to assume additional duties and often longer hours, while caring for sicker and older patients, do you find "burnout" a major factor among your nurses?

2. Do you think that rural areas of the country have a disproportionately higher number of nurses working in non-nursing fields than is the case in urban and metropolitan areas?

3. Are you aware of many nurses in Montana who have stopped practicing, but who would be willing to come back to the profession under certain circumstances? If so, how could we encourage these nurses to return?

4. How much of a factor does salary play in the overall difficulty of recruiting nurses?

5. In your view, has the shortage of nurses affected the quality of health care in rural communities?

6. Despite widespread support among residents of rural communities for their local hospital, a bias may nevertheless exist among them that health care in large, metropolitian facilities is superior. Is there any basis for this bias?

7. You noted that you would like to continue your professional education and training, but have had difficulty arranging to do so. What would you need in the way of an independent study program to continue your education?

We appreciate your taking the time to answer these questions and will, of course, forward you the final hearing print as soon as it is available. Should you have any questions regarding this request, please contact Christopher Jennings or Jennifer McCarthy of the Committee staff at (202) 224-5364.

Thank you for your cooperation and assistance with this request. We look forward to reviewing your responses.

Sincerely,

John Melcher
Chairman

FRANCES MAHON
DEACONESS HOSPITAL

621 3rd St. South
Glasgow, MT 59230
406-228-4351

July 27, 1988

Senator John Melcher
U.S. Senate
Special Committee on Aging
Washington, D.C.

Dear Senator Melcher:

This is my response to the written questions received July 26, 1988.

1. With nurses in rural areas having to assume additional duties and often longer hours, while caring for sicker and older patients, do you find "burnout" a major factor among your nurses?
Answer: No, it is not a major factor, but is present at times, most of the RN's work in more than one area of the hospital; it appears to help to have a "change of pace".

2. Do you think that rural areas of the county have a disproportionately higher number of nurses working in non-nursing fields than is the case in urban and metropolitan areas?
Answer: No, there are a couple LPNs that I know of who work in a non-nursing field, but I know of no RNs.

3. Are you aware of many nurses in montana who have stopped practicing, but who would be willing to come back to the profession under certain circumstances? If so how could we encourage these nurses to return?
Answer: Most RN's who are not practicing would probably not return to the work force. I wish I knew how to encourage them to return as there are several in the area. Hospital hours are a factor for many.

4. How much of a factor does salary play in the overall difficulty of recruiting nurses?
Answer: It has played a fairly significant part, while we are competitive, we are not at the salary level of larger hospitals. plus, if we started recruiting at a higher level, we would need to increase wages on long term RNs to be fair.

5. In your view, has the shortage of nurses affected the quality of health care in rural communities?
Answer: Yes, we are using a fair amount of temporary nurses who

have been good for the most part, but the continuity of care is interrupted. Also, when nurses have to work extra hours in addition to their regular schedule, they are tired and the quality is decreased. Myself, with working odd shifts, frequently after a 10-12 hour day, plus my skills are not as good at bedside nursing as they once were, has got to affect the quality of care.

6. Despite widespread support among residents of rural communities for their local hospital, a bias may nevertheless exist among them that health care in large, metropolitan facilities is superior. Is there any basis for this bias?
Answer: While this bias certainly exists, perhaps due to the misconception that "bigger is better", it is absolutely untrue. We have had many many people tell us of the superior care provided locally compared to the care they received in a bigger hospital.

7. You noted that you would like to continue your professional education and training, but have had difficulty arranging to do so. What would you need in the way of an independent study program to continue your education?
Answer: I am a diploma prepared RN, and I have some mixed feelings about a degree. Since I am a Director of Nursing, I should pursue a degree in nursing, but this definitely requires me to be "on campus" which I am not willing to do. I am more interested in human resources or business because that pertains more to my present working situation. I would like to see a program in Montana where I could get the necessary credits by home study, and or 1-2 day workshops so I would not have to leave the home/work situation. I would need a program geared to nursing, business education or human resources that would perhaps give me credit for my years of study from a diploma program and for years of experience in the field. Then, from there, figure out what credits would be needed to obtain a bachelors degree. Possibly this type of study could be considered for a masters program, also.

Sincerely,

Pat

Pat Nessland,
Director of Nursing
Frances Mahon Deaconess Hospital

Item 4

JOHN MELCHER, MONTANA, CHAIRMAN

JOHN GLENN, OHIO
LAWTON CHILES, FLORIDA
DAVID PRYOR, ARKANSAS
BILL BRADLEY, NEW JERSEY
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G. LAWRENCE ATKINS, MINORITY STAFF DIRECTOR

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

July 20, 1988

Kevin M. Fickenscher, M.D,
Director
Center for Rural Health Services,
Policy and Research
University of North Dakota
501 Columbia Road
Grand Forks, North Dakota 58201

Dear Dr. Fickenscher:

On behalf of myself and the other members of the Senate Special Committee on Aging, I would like to thank you for participating in the July 11 hearing on the "Rural Health Care Challenge: Part 2: Rural Health Care Personnel." We appreciated receiving your excellent testimony, which I believe will enhance our efforts, as well as those of others active in this area who review the hearing record, to effectively address shortages of health care personnel in medically underserved communties.

Due to time constraints, Senator Reid and I were unable to ask a number of questions that we believe are necessary for completing the hearing record. Therefore, we would very much appreciate your providing timely written responses to the questions listed below.

1. In 1985, over 1,350 National Health Services scholarship grantees began their first year of service. By 1992, only two are estimated to begin. What impact do you think that the phasing out of the Corps' scholarship program will have on efforts to meet health care needs in rural areas?
2. We understand that you are involved in efforts to recruit physicians into rural areas. Please tell us about this program, and whether this approach could be used in other rural areas with serious shortages in physicians and in other health care personnel.
3. In your view, how much do rising malpractice rates contribute to the problem of rural physician shortages?
4. If the Congress were to mandate the elimination of all Medicare payment differentials for rural physicians, how much of an impact do you think this would have on rural physician shortages?
5. What role do you forsee the National Advisory Committee on Rural Health, of which you are a member, having in

efforts to resolve shortages of health care personnel in medically underserved rural areas?

6. Have you come across the perception not uncommon among rural residents that health care in large, metropolitian hospitals is superior to that available in rural areas? Do you think there is any basis for a bias towards large urban facilities?

7. Do you perceive a potential for the participation of local businesses and other non-medical sectors of a rural community in efforts to overcome local health care personnel shortages?

8. In your testimony, you indicated that the increasing emphasis on baccalaureate-trained nurses was a positive development. As you know, however, many hospital administrators do not necessarily view this approach as the answer to the problem of nurse shortages. Would you please expand on your comments, specifically clarifying whether you think that more baccalaureate-trained nurses will alleviate shortages in this field.

We appreciate your taking the time to answer these questions and will, of course, forward you the final hearing print as soon as it is available. Should you have any questions regarding this request, please contact Christopher Jennings or Jenny McCarthy of the Committee staff at (202) 224-5364.

Lastly, we are enclosing a copy of the draft paper on rural health care personnel issues that was prepared in conjunction with the July 11 hearing. When completed, the paper will be incorporated into a Committee report on the rural health care system to be released later this summer. In view of your knowledge of these issues, we would appreciate your reviewing this paper and sharing with us any comments or suggestions you might have as a result. To meet our publishing deadline, we would appreciate having the benefit of your views by early August.

Thank you for your cooperation and assistance with this request. We look forward to reviewing your responses.

Sincerely,

John Melcher
Chairman

Enclosure

THE
CENTER FOR RURAL HEALTH
SERVICES, POLICY AND RESEARCH

University of North Dakota • 501 Columbia Road • Grand Forks, North Dakota 58201 • (701) 777-3848

August 16, 1988

Annabelle Richards
Senate Special Committee on Aging
G-41 Dirksen Senate Office Building
Washington, DC 20510

Dear Annabelle:

I am enclosing the answers to the questions requested by Senator Melcher. If I can be of further assistance in any capacity, please feel free to contact me at The Center.

With kindest regards, I am...

Sincerely,

Kevin Fickenscher, M.D.
Director

jsn

enclosures

In 1985, over 1,350 National Health Services scholarship grantees began their first year of service. By 1992, only two are estimated to begin. What impact do you think that the phasing out of the Corps' scholarship program will have on efforts to meet health care needs in rural areas?

Based on our experience at The Center for Rural Health, we are finding it more difficult to recruit physicians to rural areas than five years ago. We are quite concerned about the potential unavailability of physicians through the NHSC Scholarship program on physician recruitment and placement efforts for rural areas. For many rural areas throughout the nation, the NHSC-obligated physicians have been the only physician pool resource available in recruitment efforts.

Let's face it, there are rural areas of the nation that will never have an adequate supply of physicians regardless of the potential surplus. We must have a pool of obligated physicians to meet the manpower needs of these communities. As an example, certain impoverished communities and the Indian Health Service have not benefited from the surplus of physicians evident in many communities. I believe the new loan rep[illegible] substituting for the NHSC Scholarship Program [illegible] the manpower needs of selected rural areas. [illegible] attract physicians even with the option of lo[illegible] the only option is to identify obligated phys[illegible] scholarship program, that option is now no lo[illegible] the U.S. Congress will be revisiting the need [illegible] program within the next two to three years.

We understand that you are involved in effort[illegible] rural areas. Please tell us about this progr[illegible] could be used in other rural areas with serio[illegible] in other health care personnel.

The Center for Rural Health has under it's umbrella two offices; an Office of Rural Health Services (ORHS) and, an Office of Research and Policy Analysis (ORPA). Within the ORHS, The Center maintains a Health Manpower Placement Program which places physicians in rural areas throughout the Upper Midwest and Western states. The program is based on identifying and retaining stable, primary care physicians who are interested in long-term practice in a rural community. It is our belief that a community's manpower needs must be carefully matched with the personal and professional needs of an individual physician. As a result, The Center conducts personal interviews with key representatives from the community and makes recommendations on how best to sustain local health services. To recruit physicians, we individually contact primary care residents from throughout the nation, often early in the resident's training. Considerable attention is also placed on the needs of the spouse.

I firmly believe that such programs could be easily replicated around the nation. The major obstacle now is the lack of available funds to support such efforts at the state level. As an example, our Health Manpower Placement Programs costs approximately $100,000 per year inclusive of all costs. In recent months we have proposed a coordinated program to the Bureau of Health Care Delivery and Assistance but once again, the limiting factor is lack of funds. A coordinated program operated by the various states through a collaborative approach would greatly facilitate effective recruitment of primary care physicians for rural areas. In fact, with the demise of the NHSC Scholarship Program I believe the necessity of state-level programs is much more important than in the past. A Federal initiative to support such programs or encourage states to initiate such efforts could be of significant importance to the rural communities of the nation searching for physicians.

In your view, how much do rising malpractice rates contribute to the problem of rural physician shortages?

The increase in malpractice liability has not directly affected the supply of rural physicians but it has affected the type of practice of the rural physicians. The major problem with increasing liability costs has been that many rural physicians now defer the practice of obstetrics. Where physicians pay more in liability premiums than can be generated in obstetrical fees, rural physicians are forced into a situation of discontinuing selected services. There is an evolving problem in the field of obstetrical services availability in rural areas of the nation. It is particularly acute in "frontier" sections of the nation where the population base is six people per square mile or less (i.e. almost exclusively west of the Mississippi River). Aside from the decrease in certian services such as obstetrics, I do not believe the increasing costs of liability insurance have substantially affected the supply of physicians in rural areas.

If the Congress were to mandate the elimination of all Medicare payment differentials for rural physicians, how much of an impact do you think this would have on rural physician shortages?

It is difficult to estimate the potential impact of such a change of the distribution of physicians but I do believe eliminating the differential would have an impact. At the present time, a family physician practicing in a rural setting is reimbursed at a level of 25 - 35% less than his/her urban counterpart for exactly the same service. In essence, we have a situation where the rural physician must work 25 - 35% harder and see more patients to make the same income. One of the changes we have seen among young physicians is a greater respect for personal time. Too frequently I have been told by the potential recruit that "it's simply too demanding...and you don't get paid for it" to practice in a rural setting. Medical students also have much greater debt loads after graduating from medical school. The young physician when hearing of the differential is often swayed to enter a practice situation in an urban setting. It seems obvious that our reimbursement policy should reflect -- if not support -- our health manpower policy. Under the current situation, the reimbursement system serves as a disincentive to consider rural practice.

What role do you foresee the National Advisory Committee on Rural Health, of which you are a member, [illegible] in efforts to [illegible] shortages of health care personnel in medically underserved rural areas?

I believe the greatest role the National Advisory Committee on Rural Health [illegible] two-fold. First, the Committee should continue to monitor the supply of health professionals in rural areas. This function is not currently mandated for the Committee and no funds have been appropriated for this purpose. Not only is the rural health manpower problem acute for physicians but there are a host of other health professionals in short supply. For example, many rural areas have substantial difficulty in recruiting physical therapists, social workers, medical technologists and other professional personnel important in sustaining a quality health care system. Another area is in nursing. Considerable attention has been focused on the nurse shortage in urban settings but little attention has been given to the rural side of the equation. I personally believe that when the shortage finally hits rural America it will be much more difficult to address than the urban situation. Young nurse graduates are not attracted to rural areas for a host of reasons.

Second, I believe the Committee has a very important role in advising Congress and the Administration on the specific types of Federal and State manpower deployment programs needed for rural America. As an example, with the demise of the NHSC Scholarship Program, the Committee should be monitoring the impact of the new Loan Forgiveness program. In the event the program does not meet the existing need specific suggestions should be made on how best to address the manpower shortages. These suggestions can be incorporated into the annual report which is to be prepared by the Committee for Congress.

Have you come across the perception not uncommon among rural residents that health care in large, metropolitan hospitals is superior to that available in rural areas? Do you think there is any basis for a bias towards large urban facilities?

The perception that "bigger is better" is extremely common in rural areas throughout the nation. It is a perplexing problem because in most instances it is not true for primary care services which are relatively equivalent regardless of where they are provided. I personally believe the major issue with the "bigger is better" phenomenon relates to the availability of technology. Increasingly patients believe that something must be done to them. Having an x-ray with a big, new Computerized Axial Tomography (CAT) scanner is perceived as much more useful and complete than an x-ray taken at the local rural clinic. In fact, the mere presence of the machine implies that a good outcome will result from an encounter with the physician even though the technology make not be used or necessary.

I consistently suggest to the rural communities that they should provide the services they provide best -- quality primary care services. To the extent that the rural patient believes referral services are available and used by the local primary care physician, the patient will utilize and support local health care services.

Do you perceive a potential for the participation of local businesses and other non-medical sectors of a rural community in efforts to overcome local health care personnel shortages?

I firmly believe that local rural health services require the input and participation of the entire community. At The Center for Rural Health we have identified what are referred to as the "six critical sectors". These sectors include: commerce, education, religion, health care, government, and the dominant component of the local economy (e.g. agriculture). The involvement of key leaders from each of these sectors in local decisions related to health care services is crucial. From forming a physician recruitment committee to conducting strategic planning for the rural hospital to coordinating the school health program, the involvement of these six sectors makes a critical difference in the success of the efforts.

In your testimony, you indicated that the increasing emphasis on baccalaureate-trained nurses was a positive development. As you know, however, many hospital administrators do not necessarily view this approach as the answer to the problem of nurse shortages. Would you please expand on your comments, specifically clarifying whether you think that more baccalaureate-trained nurses will alleviate shortages in this field.

The nurse shortage relates to a shortage of all types of registered nurses including baccalaureate-trained individuals. I believe the baccalaureate-trained nurse (i.e. Bachelor of Science in Nursing - BSN) is able to function in many more situations as compared to other types of registered nurses. In addition, I have felt for some time that the number of different levels in nursing created confusion regarding the capability and training of many different people with the title "nurse". Furthermore, with the increasing severity of illness and case mix evident in most acute care settings, the need for nurses who can interpret the patient's problems and participate with the physician as a team member is even more necessary. Baccalaureate-trained nurses can meet this challenge.

On the issue of the nurse shortage, I believe the baccalaureate nursing profession must begin to address the significant issue of where their graduates eventually practice. As a example, in North Dakota 70% of the BSN graduates who practice are living in the four urban counties of the state. Unless the nursing profession effectively deals with the need to train "nurse generalists" or "rural nurses", I believe there will be continuing problems with the level of support for baccalaureate nursing even though in the long term these types of nurses best meet the needs for flexible capability in rural settings. However, nursing cannot meet the needs for rural nurses any more than the medical schools could meet the need for training primary care physicians a decade ago. We need a federal initiative to support rural nurse training at the baccalaureate level now. Such a program could support off-site training of nurses, outreach re-education on non-baccalaureate nurses, altered curriculums for the generalist focus of nurse training and other similar approaches which would be effective in redressing the maldistribution of baccalaureate-trained nurses.

Item 5

JOHN MELCHER, MONTANA, CHAIRMAN

JOHN GLENN, OHIO
LAWTON CHILES, FLORIDA
DAVID PRYOR, ARKANSAS
BILL BRADLEY, NEW JERSEY
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JOHN HEINZ, PENNSYLVANIA
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MAX I. RICHTMAN, STAFF DIRECTOR
G. LAWRENCE ATKINS, MINORITY STAFF DIRECTOR

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

July 20, 1988

The Honorable David N. Sundwall, M.D.
Administrator
Health Resources and Services Administration
Parklawn Building, Room 14-05
5600 Fishers Lane
Rockville, Maryland 20857

Dear Dr. Sundwall:

On behalf of myself and the other members of the Senate Special Committee on Aging, I would like to thank you for participating in the July 11 hearing on the "Rural Health Care Challenge: Part 2: Rural Health Care Personnel". We appreciated receiving your excellent testimony on how the Health Resources and Services Administration (HRSA) is helping to meet the need for health care personnel in underserved rural areas and related issues of mutual concern.

Due to time constraints, Senator Grassley and I were unable to ask a number of questions that we believe are necessary for completing the hearing record. Therefore, I would very much appreciate your providing timely written responses to the questions listed below.

1. The Reagan administration has not supported increases in funding for most of the health manpower programs. In fact, it has called for reductions in some of them. Have problems of the sort recounted by the witnesses at the July 11 hearing -- namely, serious shortages in rural doctors, nurses, and allied health personnel -- led the Administration to reconsider its approach in these areas?

2. In your testimony, you stated that the National Health Service Corps is still alive and kicking. However, there can be no dispute that the supply of scholarship recipients has radically decreased. The declining support for this program doesn't appear to be consistent with the fact that we are still facing physician and allied health personnel shortages in low-population rural areas and inner-city communities. Even the President's own AIDS commission has recommended an expansion of the Corps to meet the future needs of AIDS patients. In light of the continuing and projected physician shortages, how can we meet these needs without significantly expanding the Corps?

3. The loan repayment program you mentioned in your testimony is an interesting and promising concept. However, I understand that it has been difficult to attract residents to this program, and in the first six months of the fiscal year fewer than 40 physicians were recruited. Is this correct, and how would you evaluate the success of this recently implemented program? How can we improve this program?

4. How many physicians are expected to practice in medically underserved areas under the loan repayment program in coming years?

5. What are the advantages and disadvantages of the loan repayment approach relative to the Corps's scholarship program? Do you anticipate any problem with physicians in the loan repayment program not fullfilling their contract?

6. As became obvious during the course of this hearing, the Committee is very concerned about nursing shortages. You acknowledged that HRSA does have the legislative authority to use National Health Service Corps financing to support and place nurses in medically underserved areas. How many nurses has the Corps actually placed in medically underserved areas in the last five years? Do you think we should expand our efforts under this program to overcome nurse shortages in such areas?

7. Please provide a detailed description of the programs you mentioned during your oral testimony that have been successful in recruiting and retaining nurses and other allied health personnel?

8. Do you forsee any other HRSA activities in the near future that will work toward attracting allied health professionals to medically underserved areas? If so, please briefly describe them.

9. Over the last eight years, the Senate Appropriations Committee has expressed its desire for receiving information on underserved mental health shortage areas. Members of the Aging Committee recently received copies of a new study of mental health providers in six states. This study, completed by the National Association of Social Workers, found that great numbers of counties, in mostly rural areas, are either underserved or not served at all by mental health providers. Does this finding surprise or concern you? What steps, if any, should HRSA take to address this problem?

10. Community health centers (CHCs) in many rural areas play a vital role in assuring care to increasing numbers of underinsured and uninsured populations. However, in many remote rural areas, there are few or no community health centers. For example, in North Dakota, there is only one community health center and in Montana there are only two. Why do you believe that there are so few CHCs in remote rural areas and what role, if any, do you believe a CHC can play in these communities?

11. Should special funding be allocated for an initiative for CHC-like facilities in underserved frontier areas?

12. Senator Grassley has raised concerns that HRSA diverted a portion of the funds appropriated for Rural Health Centers through the Office of Rural Health Policy. Given the modest amount of money alloted by Congress for that program, shouldn't all of it be provided to the Centers?

13. You mentioned in your testimony that the National Advisory Committee on Rural Health, led by Bob Ray from Iowa, has been empaneled. Will the Committee have sufficient resources, including staff and travel funds, to fully carry out its responsibilities?

We appreciate your taking the time to answer these questions and will, of course, forward you the final hearing print as soon as it is available. Should you have any questions regarding this request, please contact Christopher Jennings or Jennifer McCarthy of the Committee staff at 224-5364.

Thank you for your cooperation and assistance with this request. We look forward to reviewing your responses.

Sincerely,

John Melcher

Chairman

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

July 22, 1988

The Honorable David N. Sundwall, M.D.
Administrator
Health Resources and Services Administration
Parklawn Building, Room 14-05
5600 Fishers Lane
Rockville, Maryland 20857

Dear Dr. Sundwall:

In my July 20, 1988 letter to you, we inadvertently neglected to include a question that I would appreciate your addressing when you forward your responses to the other questions.

Question 14. I have recently been made aware that the Health Resources and Services Administration (HRSA) may be seriously considering a plan to place National Health Service Corps (NHSC) physicians in urban hospitals to care for AIDS patients. While the need for additional physicians to care for these patients cannot be disputed, I am concerned that these placements will be at the expense of rural and urban primary care sites in medically underserved areas. Can you give the Committee assurances that, should Corps physicians be utilized for the treatment of AIDS patients, additional resources will be dedicated to this effort and it will not be at the expense of rural areas that are currently designated as medically underserved?

Thank you for your continued cooperation and assistance with this request. We look forward to reviewing your response to this question and the other questions I previously forwarded to you.

Sincerely,

John Melcher
Chairman

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of the Secretary
Washington, D.C. 20201

August 23, 1988

NOTE TO: Jennifer McCarthy
Staff Assistant
Senate Special Committee on Aging

SUBJECT: Q's and A's from July 11 hearing

Enclosed are all but one of the Q's and A's. We are still reviewing the one concerning facilities in frontier areas, and I hope to have it ready in a few days if you can hold room for it in the hearing record.

Ed McGroarty, L/H
245-7450

Q:

You mentioned in your testimony that the National Advisory Committee on Rural Health, led by Bob Ray from Iowa, has been empaneled. Will the Committee have sufficient resources, including staff and travel funds, to fully carry out its responsibilities?

A:

In FY 1989 we will provide all of the resources the Advisory Committee requires to fulfill its responsibilities. Depending on the level of funding provided to HRSA in FY 1989, it may be necessary to use some of the funds appropriated for the Rural Health Research Center grant program.

Q: Senator Grassley has raised concerns that HRSA diverted a portion of the funds appropriated for Rural Health Centers through the Office of Rural Health Policy. Given the modest amount of money allotted by Congress for that program, shouldn't all of it be provided to the Centers?

A: When the Office of Rural Health Policy was created the cost of salaries, supplies and other expenses placed a burden on the HRSA budget that could not be fully met with the existing program management funds. No additional funds were made available to support the National Advisory Committee on Rural Health which was established by the Secretary and strongly endorsed by Members of Congress. During FY 1988, a portion of the funds made available for the Office of Rural Health were used to support these activities.

Q: Community health centers (CHCs) in many rural areas play a vital role in assuring care to increasing numbers of underinsured and uninsured populations. However, in many remote rural areas, there are few or no community health centers. For example, in North Dakota, there is only one community health center and in Montana there are only two. Why do you believe that there are so few CHCs in remote rural areas and what role, if any, do you believe a CHC can play in these communities?

A: Currently, about two-thirds of the 600 community health center grantees provide access to primary care services in rural areas. While it is true that Montana and North Dakota have small numbers of CHCs, both states have other federally funded services through the National Health Service Corps and the Indian Health Service. Each rural area is different in terms of population size, geographic isolation and proximity to inpatient services. The design of its delivery system must be considered in that context and the aggregate health care resources of State and local governments as well as the private sector. Community health centers are playing a role in meeting the health care needs of some remote rural areas; however, the CHC model is not appropriate for all communities.

Q. The Reagan administration has not supported increases in funding for most of the health manpower programs. In fact, it has called for reductions in some of them. Have problems of the sort recounted by the witnesses at the July 11 hearing — namely, serious shortages in rural doctors, nurses, and allied health personnel — led the Administration to reconsider its approach in these areas?

A. The Administration continues to believe that the Federal Government can best utilise funds to accomplish national priority health personnel objectives under a flexible authority that allows the Government to encourage cooperative efforts by States and communities to identify needs and develop programs to meet those needs. Within the Administration's proposed Cooperative Health Professions Initiatives authority, we would favor emphasizing activities to enhance the availability of health personnel in rural or other underserved areas. One of the advantages of the proposed authority would be that it would allow rapid response to emerging health care requirements such as the need for additional health personnel in rural areas.

Q. Do you foresee any other HRSA activities in the near future that will work toward attracting allied health professionals to medically underserved areas? If so, please briefly describe them.

A. As instructed by the Congress in Public Law 99-129, the Health Resources and Services Administration has arranged with the Institute of Medicine of the National Academy of Sciences to conduct a study concerning the role of allied health personnel in health care delivery. One of the purposes of the study, which is near completion, has been to assess the role of the Federal, State, and local governments, educational institutions, and health care facilities in meeting requirements for various types of allied health personnel. Staff in HRSA have been reviewing a preliminary report on the study. During coming months, we will consider the desirability and feasibility of carrying out the recommendations in the final report. We expect a number of these recommendations to bear on the need for attracting allied health professionals to medically underserved areas.

Q: In your testimony, you stated that the National Health Service Corps is still alive and kicking. However, there can be no dispute that the supply of scholarship recipients has radically decreased. The declining support for this program doesn't appear to be consistent with the fact that we are still facing physician and allied health personnel shortages in low-population rural areas and inner-city communities. Even the President's own AIDS commission has recommended an expansion of the Corps to meet the future needs of AIDS patients. In light of the continuing and projected physician shortages, how can we meet these needs without significantly expanding the Corps?

A: Given the enhanced capability of the National Health Service Corps and the Public Health Service to recruit physician and allied health personnel and utilizing the new loan repayment program as an incentive to recruitment, we believe we can significantly increase the number of health care practitioners available for practice in underserved areas. Assuming an $8 million appropriation in '89, we believe we can recruit 400 physicians if the total appropriation were applied to physician recruitment or 300 physicians and 200 nurses assuming a 3 to 1 split.

Q. The loan repayment program you mentioned in your testimony is an interesting and promising concept. However, I understand that it has been difficult to attract residents to this program, and in the first six months of the fiscal year fewer than 40 physicians were recruited. Is this correct, and how would you evaluate the success of this recently implemented program? How can we improve this program?

A. By July 11, the date of testimony, the NHSC Loan Repayment Program had mailed out over 600 applications for participation and received back 70. Considering the newsness of the Program and the lateness in the academic year, we believe this better than 10% return is encouraging.

Of these 70 applicants, 35 health professionals were selected to match to high priority Health Manpower Shortage Area sites with their practice to begin in 1988 (23), 1989 (11), and 1990 (1).

The Program lost many potential applicants in this its first year because many physicians had already accepted other positions before the Program was available to them. By making Program information and lists of available vacancies available in the fall of 1988 we believe many more of those completing residencies in 1989 will apply. This fall we plan to send NHSC Loan Repayment Program notices to over 12,000 physicians in residency programs of family practice, obstetrics/gynecology, and osteopathic general practice.

The eventual success of the Program will be determined by the number of applicants matching to an NHSC Loan Repayment Service Site who actually begin their service and for whom we agree to repay their outstanding qualified health education loans.

Q: How many physicians are expected to practice in medically underserved areas under the loan repayment program in coming years?

A: We cannot answer this question at this time because we still have the program implementation plans under study and also because we are uncertain about the level of appropriations.

Q. What are the advantages and disadvantages of the loan repayment approach relative to the Corp's Scholarship program? Do you anticipate any problem with physicians in the loan repayment program not fulfilling their contract?

A. Advantages of Loan Repayment Approach:

Immediate Availability of Needed Specialists: The Loan Repayment Program obtains health care providers for professional practice in the specialties most needed by the Secretary in the same year (or the year after) they are accepted for participation. This contrasts with the Scholarship Program which often has a 6-year delay between the start of scholarship support and the start of practice. During this delay the primary care specialty direction intended by the Scholarship participant may change to a non-primary care field, leading to conflict with the goals of the NHSC and, ultimately, defaulting on the terms of the Scholarship. The default rate under a Loan Repayment approach should be significantly less than that of the Scholarship Program approach.

> Site Suitability: The Loan Repayment Program allows participants to match to the available NHSC or Indian Health Service sites of their choice before we agree to their participation in the loan repayment program. If they do not match to a site, they are under no obligation because no loan repayment funds have been paid on their behalf. By contrast, scholarship participants are obliged to serve without knowing until many years later where they will be serving. The Loan Repayment program therefore should result in a much larger number of participants who are satisfied with the practice positions they have chosen and who can be expected to complete their Loan Repayment Program service obligation.

Disadvantages of the Loan Repayment Approach:

> Personnel Planning More Difficult: Under the scholarship program approach the NHSC and the IHS were able to accurately project the availability of scholars for service for five or more years ahead and could plan their medical specialty needs accordingly. Such planning is limited under the loan repayment program since an unpredictable number and mix of needed specialists are available each year for matching and placement.

Q: As became obvious during the course of this hearing, the Committee is very concerned about the nursing shortages. You acknowledged that HRSA does have the legislative authority to use National Health Service Corps financing to support and place nurses in medically underserved areas. How many nurses has the Corps actually placed in medically underservied areas in the last five years? Do you think we should expand our efforts under this program to overcome nurse shortages in such areas?

A: Until recently the majority of health care delivery systems staffed by the NHSC (with the exception of the Indian Health Service) have not experienced untoward difficulty in recruiting and retaining nursing personnel. A total of 77 nurses have been placed in health manpower shortage areas in the last five years.

As the shortage of nurses, especially in isolated rural areas, becomes more severe, we may want to consider a mechanism whereby the Federal government could aid and assist States in recruiting nurses.

Q: Please provide a detailed description of the programs you mentioned during your oral testimony that have been successful in recruiting and retaining nurses and other allied health personnel.

A. The NHSC as the lead agency in recruitment of nurses for the PHS established a special nurse recruitment activity in February 1988. Since the initiation of this effort there has been a good degree of coordinating and networking across agencies within the PHS and reaching out to schools of nursing, nursing organization, etc. We fully expect that these efforts willl improve the PHS as a whole and the individual agencies within the PHS to become more successful in these nurse recruitment and retention activities.

Specifically, during the 1987-1988 recruitment year the Indian Health Service (IHS) has been able to recruit and place 400 nurses. The IHS has succeeded in their recruitment efforts through a variety of recruitment strategies including decentralized recruitment efforts, local hiring and placement initiatives, and a nurse scholarship program which enabled the IHS to attract some 100 of the 400 nurses recruited.

In addition, the COSTEP program has increased its level of success in recruiting nursing students into the PHS by 30 percent within the last 6 months, and a senior nurse COSTEP program will be initiated within the next several months.

Q: Over the last eight years, the Senate Appropriations Committee has expressed its desire for receiving information on underserved mental health shortage areas. Members of the Aging Committee recently received copies of a new study of mental health providers in six states. This study, conducted by the National Association of Social Workers, found that great numbers of counties, in mostly rural areas, are either underserved or not served at all by mental health providers. Does this finding surprise or concern you? What steps, if any, should HRSA take to address this problem?

A: Because the National Association of Social Workers study of mental health providers in six States (Florida. Illinois, Michigan, Oklahoma, Texas and West Virginia) was done at the county level, it does not take into account the fact that mental health service areas (or catchment areas) often involve multiple counties; services at a central point may be provided to residents from a group of counties surrounding that point. Thus, not all those counties which have either no mental health providers or only social workers should necessarily be considered mental health care shortage areas. Some will be found located contiguous to other counties with adequate or more-than-adequate numbers of psychiatrists and psychologists. If the travel time across the county line to the contiguous area resources is not excessive, and particularly if the two counties involved are considered part of the same catchment area for purposes of that State's system of mental health services, the county's needs may be being met.

Nevertheless, the NASW study identified significant numbers of counties in each of these States which had no mental health providers (defined as psychiatrists, licensed psychologists and licensed social workers) or had only social workers. In five of these six States (all but Texas), the number of counties identified is approximately equal to the number of counties already designated by the Health Resources and Services Administration as part of psychiatric health manpower shortage areas (HMSAs); in Texas, the NASW has identified a much greater number of counties than the HMSA designation process. Comparison of the NASW results with our own HMSA results for the five States other than Texas shows that approximately 63% of the counties identified by NASW as having no mental health providers or only social workers have already been designated as psychiatric care HMSAs. To that extent, we are not surprised by the study's findings; certainly we are concerned about underservice in these or other areas.

Although 32 of the NASW-identified counties in these five States have not been designated as HMSAs, 87 other counties not identified by NASW have been HMSA-designated by HRSA. The lack of a one-to-one correspondence here is due to a combination of our exclusion of those counties with contiguous area resources available and our inclusion of other counties in catchment areas having some psychiatrists but whose population-to-psychiatrist ratios are excessive, together with differences in currency of data. The much larger number of NASW-identified counties in Texas is likely due to the catchment area effect; Texas county sizes are fairly small, terrain is flat and highways straight, so that fairly large numbers of counties are typically included in catchment areas served from a central county. Another reason for the lack of rural county psychiatric HMSA designations in Texas is that Texas has not requested such designations; Texas has instead emphasized their needs for psychiatrists in correctional facilities.

The limited numbers of National Health Service Corps-obligated psychiatrists available for placement in recent years have been assigned almost exclusively to rural shortage areas, and that policy continues to be in effect for the current placement cycle which just began. We support the idea of taking the distribution of psychologists and social workers as well as psychiatrists into account in making decisions about allocation of National Health Service Corps psychiatrists (and any other resources relating to the provision of mental health care).

Q. I have recently been made aware that the Health Resources and Services Administration (HRSA) may be seriously considering a plan to place National Health Service Corps (NHSC) physicians in urban hospitals to care for AIDS patients. While the need for additional physicians to care for these patients cannot be disputed, I am concerned that these placements will be at the expense of rural and urban primary care sites in medically underserved areas. Can you give the Committee assurances that, should Corps physicians be utilized for the treatment of AIDS patients, additional resources will be dedicated to this effort and it will not be at the expense of rural areas that are currently designated as medically underserved?

A. It is true that the HRSA has received a number of requests to date from several urban hospitals to assist them in staffing their AIDS units on an inpatient basis. We are studying these requests very closely from several perspectives: a determination of need basis, an inpatient versus ambulatory care perspective and a system of care perspective. From the perspective of need, it is not at all clear that urban hospitals are experiencing unusual difficulties in recruiting physicians to staff "AIDS units"; it is also unclear that the majority of medical care which is required in meeting the range of services required in treating persons with AIDS are delivered in an inpatient setting, and finally we strongly believe that services rendered to persons with AIDS need to be provided as part of and within a system of care that deals with the whole person and not simply with the person who is admitted as an inpatient for acute episodes of the illness.

The availability of well trained medical practitioners in rural communities is vital to the continued survival of the systems of care which residents of these communities depend upon. Both areas of need are real, however, and need to be addressed by the NHSC utilizing the resources it has at its disposal.

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Washington, D.C. 20201

AUG 26 [illegible]

NOTE TO: JENNIFER MCCARTHY
Staff Assistant
Senate Special Committee on Aging

SUBJECT: Q's and A's from July 11 Hearing

Here is the final Q and A. Thank you again for giving us the time to get everything into the record.

Edward McGroarty, L/H
245-7450

Enclosure

Q: Should special funding be allocated for an initiative for CHC-like facilities in underserved frontier areas?

A: We do not feel that the allocation of special funding for CHC-like facilities in underserved frontier areas is necessary. The community health center legislation recognizes frontier areas and the program does have grantees or satellite clinics in a number of frontier areas. Each rural community is different and the delivery model appropriate for an area must take this uniqueness into consideration. The community health center program is continuing to work with other interested public and private groups to explore ways to improve access to primary care services in frontier areas.

Q: Should special funding be allocated for an initiative for CHC-like facilities in underserved frontier areas?

A: We do not feel that the allocation of special funding for CHC-like facilities in underserved frontier areas is necessary. The community health center legislation recognizes frontier areas and the program does have grantees or satellite clinics in a number of frontier areas. Each rural community is different and the delivery model appropriate for an area must take this uniqueness into consideration. The community health center program is continuing to work with other interested public and private groups to explore ways to improve access to primary care services in frontier areas.

APPENDIX 5.—WRITTEN TESTIMONY PERTAINING TO HEARING

Item 1

Senator Daniel K. Inouye

STATEMENT FOR THE RECORD

The Rural Health Care Challenge: Part 2: Rural Health Care Personnel

I would like to commend Senator Melcher and the members of the Special Committee on Aging for conducting this hearing on rural health care personnel. Access to health providers for our nation's rural residents has always been a particular concern of mine. With drought causing crop failures in many rural areas and dramatically increasing the stresses felt by families, we are particularly aware at this time of the barriers these families face when trying to obtain mental health services. It is well known that elderly citizens are among those groups prominent in the rural populations who would benefit from better access to mental health services.

While some rural citizens may have access to providers of one or more of the four core mental health professions (psychologists, clinical social workers, psychiatrists, and psychiatric nurses), many do not. Some of our health policies, in fact, create unnecessary barriers in the rural areas where mental health professionals are present. For example, while social workers are the largest providers of professional mental health services in this country, rural health clinics cannot now fully utilize clinical social worker's expertise.

Presently, under the Department of Defense CHAMPUS Program and the Federal Employees Health Benefits Act, clinical social workers are deemed autonomous providers and beneficiaries have direct access to their services. I believe that it is equally important for citizens of rural America, who rely on Medicare or Medicaid reimbursement, to have a similar choice. Therefore, I have introduced S.2163 which would allow clinical social workers to be utilized more effectively by rural health clinics, pursuant to State statute.

I urge the Committee to stress the importance of improving access for rural Americans to health care by promoting passage of S.2163 and other bills which will allow our nation's elderly and all citizens to obtain the care they need.

Item 2

AMERICAN ACADEMY OF NURSE PRACTITIONERS
179 PRINCETON BLVD. LOWELL, MA 01851 617 937-7343

Testimony of the
American Academy of Nurse Practitioners
submitted to the Senate Special
Committee on Aging

regarding

Utilization of Nurse Practitioners
in Care of the Rural Aging Population

submitted by

J. Towers PhD, CRNP

This document is submitted in behalf of the American Academy of Nurse Practitioners to address the role of nurse practitioners in health care of elderly citizens living in rural America.

As has been noted in numerous studies (1,2,3,4,5,6,7,8,9) Nurse Practitioners have demonstrated their ability to provide high quality, cost effective primary care to citizens of all ages and in all geographic locations.

As has also been noted, in the most recent report from the Office of Technology Administration (10), Nurse Practitioners are particularly well suited to care for the elderly due to their dual preparation in nursing and medical arenas. This preparation enables nurse practitioners to manage the chronic and acute medical conditions which commonly affect the elderly. In addition, they are prepared to assist the elderly in attaining and maintaining a higher quality of life by guiding and supporting their health promoting activities of both an emotional and physical nature.

According to preliminary findings from the national survey conducted by the American Academy of Nurse Practitioners (11), Nurse Practitioners practice in rural areas in all fifty states. The majority are Family Nurse Prpractitioners. In very rural communities (population <1000) they are found predominantly in free standing primary care center and public health clinics. In semi-rural areas and small towns (population 1000-49,000) they are practising predominantly in free standing primary care centers, public health clinics and in private practices, usually with a physician. Seventy percent of all Nurse Practitioners functioning in rural areas have eldery people among their patients.

Yet with this documented track record for both quality and cost effective care, only 13% of the Nurse Practitioners in very rural and 10% in semi-rural areas have nursing home privileges and only 29% in both groups have hospital privileges. In addition, of the 48% of those practicing in very rural areas and 35% in semi-rural areas who provide services that are reimbursable through third party payment less than 5%, (4.9% in very rural and 3.8% in semi-rural areas) obtain direct reimbursement for their services (12).

In a pilot study initiated by the Academy, Rural Nurse Practitioners, were asked to identify the factors which most contributed to their satisfaction as a Rural Nurse Practitioner. The factor most commonly rated #1 was autonomy (13).

Given the above data, the barriers to retaining and increasing the utilization of nurse practitioners in rural areas becomes obvious. The quality of care and cost effectiveness of nurse practitioners have been demonstrated over and over again, yet their inability to obtain their party reimbursement (in the case of the elderly: medicare reimbursement), the inability to practice in extended care facilities and to provide services in rural hospitals ties the hands of these highly competent health care providers . Such barriers make functioning in rural settings frustrating and consequently undesirable to potential practitioners.

Given this set of problems, the following are legislative solutions which could contribute to the alleviation of this situation.

1. Provision of medicare reimbursement for medical services provided by nurse practitioners in extended and primary care facilities other than rural health clinics.

Under the current law, elderly patients (other than those being seen in federal rural health clinics) who wish to see a Nurse Practitioner, are forced instead to see a physician in order to have their care reimbursed by Medicare. Nurse Practitioners rate high in consumer satisfaction; they have been demonstrated to be cost effective (14). The provision of Medicare reimbursement to Nurse Practitioners for medical services rendered would not add to the expense, but rather reduce the expense of providing health care to the elderly. Record (15) and Denton (16) in their investigations, calculate savings of $300,000,000 to $1,000,000,000 per year if Nurse Practitioners were used to provide the services they are qualified to provide.

2. Ensuring that the 1988 authorization levels of funding Nurse Practitioner programs via Title VIII be appropriated so that more Nurse Practitioners may receive stipends and assistance with educational costs.
3. Recruitment of nurses from rural areas into Nurse Practitioner programs via scholarships and educational stipends in order to facilitate their return to those areas.

Questions have been raised regarding the ability to keep nurses with advanced preparation in rural areas, particularly those with Masters degrees and higher. According to the Academy survey, 32% of the respondents from the very rural areas had Masters degrees and 34% from the semi-rural areas had Masters or Doctorates. Even in the presence of the problems discussed above Masters prepared Nurse Practitioners do stay and practice in rural areas. It seems logical that with better working and reimbursement conditions, even more would be interested in functioning in this environment.

4. Provision of GME funds to agencies and institutions in rural areas for preparing Nurse Practitioners to work with the elderly.

Studies indicate that students who have an opportunity to have learning experiences in rural settings often find practicing in such a setting rewarding enough to return after graduation. Enabling rural agencies to provide practice sites for Nurse Practitioners students through this funding would greatly facilitate rural communities in their recruitment and retention of Nurse Practitioners.
5. Providing opportunities for increased access to continuing education through scholarships and increased funding for services to rural health settings.

The ability to network with other professionals and remain current in their specialty, assists practitioners in maintaining an attitude of satisfaction, regardless of practice site, but particularly among those in more isolated geographic areas. Facilitating such services would enhance the retainability of the Rural Nurse Practitioner.

In Summary, Nurse Practitioners are viable and valuable health care providers in rural communities. With additional enabling legislation such as that described above, the ability to recruit and retain those providers will be greatly enhanced.

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Item 3

AAPA

AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

950 North Washington Street • Alexandria, Virginia 22314 • 703/836-AAPA
FAX: 703/684-1924

August 19, 1988

The Honorable John Melcher
Chairman
Senate Special Committee on Aging
SD -G41 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Melcher:

Enclosed please find the Academy's comments on rural health manpower. This is submitted for inclusion in the record of the hearing you conducted recently on rural health manpower problems.

Your commitment to improving the quality of life for rural America is to be commended. Health manpower is a serious issue in rural America and deserves the attention you have afforded it via these hearings.

The Academy looks forward to working with you and your staff in the coming months to develop solutions to the problems your hearings have identified. If we can be of any further assistance, please let us know.

Sincerely,

Bill

Bill Finerfrock
Director of Federal Affairs

Enclosure

"Rural Health - Manpower Crisis"

Bill Finerfrock
Director of Federal Affairs
American Academy of Physician Assistants

Mr. Chairman, on behalf of the American Academy of Physician Assistants and the nearly 20,000 PAs and students we represent, let me thank you for this opportunity to present our views on rural health manpower problems, particularly as they relate to PAs. This is a serious problem and we commend you for your efforts in this area.

In 1980, the Graduate Medical Education National Advisory Committee (GMENAC) reported that by the 1990's, the United States would be experiencing a physician surplus. At the time, the GMENAC report was considered the most definitive study on U.S. physician manpower needs. As such, it has had a tremendous impact on federal and state health manpower training decisions (both physician and non-physician).

A variety of theories were offered on how health care delivery and access to health care would be affected by the projected "surplus". Our testimony, Mr. Chairman, will attempt to look at health care delivery since GMENAC, particularly rural health care delivery. Our criticisms of GMENAC are intended in a constructive manner. We recognize, as any good "Monday morning quarterback" knows, that it is easy to look back on events and criticize the decisions that were made.

GMENAC's Predictions - Physician Dispersal

Foremost among the many post-GMENAC manpower theories has been the hypothesis that the rural physician manpower shortages that existed in the 1960's and 1970's would gradually be eliminated through dispersal of physicians from over-crowded urban and suburban practices into the rural manpower shortage areas.

To a degree, the predicted dispersal has occurred but certainly not to the extent needed to meet demand. One need only look at the list of rural communities designated as medically underserved by the federal government to see that severe health manpower shortages continue to be a reality. If one were to include medically underserved communities using state instead of federal definitions, the list would be even longer.

Recent changes in Medicare reimbursement rates for rural practitioners, adoption of policies intended to encourage providers to practice in rural medically underserved communities, such as creation of a new National Health Service Corps loan repayment program and expansion of the Indian Health Service scholarship program, all serve to underscore the rural health manpower shortage problem.

Demand for Non-Physician Providers

Another post-GMENAC assumption has been that the physician surplus would result in restrained growth in demand for non-physician providers such as physician assistants (PAs), nurse practitioners (NPs) and certified nurse mid-wives (CNMs). Commissioners argued that as "physician substitutes", these practitioners would not be necessary if society were able to produce a sufficient number of physicians to meet demand.

These assumptions have led many federal health policy leaders to recommend significant reductions in manpower training programs for both physicians and non-physicians. Cutbacks in health manpower training, combined with the failure of the GMENAC projections to materialize, have led to a serious health manpower crisis in rural America.

In response to the nursing shortage, significant increases have been recommended for both Nurse Practitioner and Nurse Midwifery training programs. At the present time, these proposals appear to be gaining considerable support at the federal level. We applaud these initiatives.

GMENAC's Failures

However, as we all know, GMENAC's projections of a physician surplus have recently come under attack. Schwartz & Sloan recently published an article in The New England Journal of Medicine suggesting that instead of a surplus of physicians in the '90s, we could be looking at a shortage (NEJM April 7, 1988). Consequently, many of the health manpower training decisions that flowed from GMENAC must also be questioned.

According the Schwartz & Sloan, GMENAC failed to consider the number of physicians in academic or research positions who would not be available for clinical practice. In addition, other studies erred in their assessment of the impact of the movement of patients into prepaid group practices (particularly the number of over-65 in those systems). Thus severely underestimating the demand for physician services.

With respect to non-physician providers, GMENAC failed to anticipate that consumers and employers (physicians, hospitals, clinics, etc.) would find non-physician providers attractive because of the unique skills they bring to a medical practice. In viewing non-physician providers as "physician substitutes", GMENAC failed to give these practitioners their just place in health care delivery.

While GMENAC did not suggest the elimination of these providers it certainly painted a more restrained growth rate than has actually been experienced.

All of this leads one to conclude that the nursing shortage that has captured the attention of the popular media could just be the tip of the iceberg. Profound shortages in a whole range of health professions may be staring us in the face. Failure to address those problems now will have dire consequences for rural America.

Federal Health Manpower Training in the '80s - PAs

The federal government's response to GMENAC as it pertains to the training of physician assistants is a good example of bad policy emanating from flawed data.

Since the early '80s the amount of federal support for physician assistant training has remained virtually unchanged. Indeed, Mr. Chairman, if one factors in inflation, the "real" value of those dollars has decreased. This was in direct response to GMENAC's projections of slow growth in the non-physician provider community. Consequently, the number of PA graduates per year has not changed to any large degree for the past several years.

On the demand side, the picture has been quite different. The facts are that over the past few years, the PA profession has experienced unprecedented demand. PA programs are reporting an average of 7.5 jobs per graduate for the 1988 class. In addition, starting salaries for new PA graduates are at an all-time high (average $26,500).

The failure of manpower planners to accurately predict demand for PA services during this decade is leading to serious problems for rural America. Of all primary care providers, PAs have shown the greatest likelihood of practicing in a rural setting.

Since their inception in the mid-'60s, PAs have had a love affair with rural America -- more so than any other health care practitioner. The Office of Technology Assessment (OTA) estimates that more than 30% of all PAs are practicing in rural communities. This, according to OTA, is compared to 14% of physicians and 9% of all Nurse Practitioners. In addition, more than 60% of all PAs are in primary care.

Unfortunately, this affair is being strained to the limits. Many of the PAs practicing in rural communities are getting older (many were in their late 30s when they entered the profession 20 years ago). Many are beginning to feel the effects of isolation. And finally, many are beginning to hear the Siren call of urban America.

According to Schwartz, et al, we can anticipate strong demand for PAs in the hospital sector over the next 10 years. This is in direct response to reductions in the overall numbers and hours worked by residents. Schwartz projects the need for over 11,000 non-physician providers in hospitals alone over the next 10 years simply to care for patients traditionally served by residents. Under current supply projections, PA programs will only produce 12,000 graduates over the next 10 years.

Changing Marketplace

It is not unreasonable to expect to see a decrease in the percentage of PAs practicing in rural communities within the near future. According to PA programs, the greatest increase in demand for PAs has been identified in hospitals and in prepaid group practices. In addition, strong demand is projected for geriatric and long-term care facilities.

Medical specialties and sub-specialties have recently begun to discover the value of bringing a PA into the practice. As a result programs have reported dramatic increases in opportunities in the "non-primary care" areas of medicine. Today, PAs can be found in virtually every medical specialty and subspecialty.

If demand in non-traditional settings escalates and supply remains low, as predicted, it will become increasingly difficult for rural areas to attract and retain PAs, in much the same way they have had difficulty attracting and retaining physicians.

Older PAs will become "burned out" by the isolation of a rural practice and find the urban hospital or HMO, with its higher salaries, set hours of work and access to the latest technology attractive and enticing.

Furthermore, reductions in federal training grants for PA students will force PA programs to eliminate expensive rural clinical rotations from their curriculum. This will result in fewer and fewer students being exposed to the "rural health care experience" during the clinical phase of their training thus leading to fewer PAs selecting this type of practice upon graduation.

Solution

We know from experience that the best way to ensure that a health care practitioner, whether it be a physician, NP or PA will choose a rural practice is to:

1. Recruit individuals from these communities to attend your program, or;
2. Expose students to these practice settings during the clinical phase of training.

Recruiting individuals from rural communities and providing rural clinical rotations is a very expensive undertaking regardless of the health professional you are training. In recognition of this, the federal government has made moneys available to PA programs to subsidize these activities. The fact that PAs choose rural practices at a rate double or triple that of other health practitioners is evidence of the success of this program.

Unfortunately, Mr. Chairman, some in Congress are proposing that the federal government de-emphasize the training of PAs at a time when rural areas are going to be experiencing the greatest difficulty in attracting practitioners to their communities. Unless federal health manpower policy makers reassess attitudes towards PAs, we can anticipate that the PA community like the physician community, will be unable to meet projected demand.

Conclusion

Interestingly enough, the de-emphasis on the manpower end of the equation is occurring at a time when the Congress has recently changed Medicare reimbursement policies to encourage the utilization of PAs in rural practices. The 1987 Omnibus Budget Reconciliation Act included a change which will allow for Medicare Part B coverage of PA services provided in rural health manpower shortage areas at a rate not to exceed 85% of the physician's prevailing charge. This change goes into effect on January 1, 1989.

Instead of decreasing funds for the training of PAs for rural practice, manpower planners should be recommending increases. PAs are a viable option but something must be done to turn around the thinking of those making health manpower decisions. Health manpower shortages are a reality - not a theory - and that reality must be addressed.

Mr. Chairman, rural America has the right to ask: If not PAs, Who? -- If not now, When?

Item 4

American Dental Association

STATEMENT

OF THE

AMERICAN DENTAL ASSOCIATION

ON

RURAL HEALTH CARE FOR THE ELDERLY

TO THE

UNITED STATES SENATE

SPECIAL COMMITTEE ON AGING

JULY, 1988

Washington Office: 1111 14th Street NW Washington DC 20005 (202) 898-2400

American Dental Association's

Statement on Rural Health Care
Presented to the Senate Special Committee on Aging
July, 1988

The American Dental Association welcomes this opportunity to comment on issues relative to provision of oral health care services in rural areas. Particular attention will be given to the needs of the elderly in this context.

In 1979, the Association adopted a report titled, "Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care." This report identifies five population groups which experience difficulty in accessing dental health care services due to circumstances which are largely beyond their control: the poor and working poor; the elderly; the handicapped, institutionalized and homebound; remote area residents and uninsured workers.

The issuance of this report launched a nationwide effort by the dental profession to seek ways in which barriers to receipt of dental care by these population groups could be reduced or eliminated. The elderly and handicapped populations were selected for priority attention within the overall effort. It was the Association's belief then, as it is now, that existing professional resources were adequate to meet the demand for dental care by the population as a whole and by these special groups in particular.

The fundamental problems in improving access for these populations are their misperceptions about the need for dental care; inadequate funding for dental care in public health programs, and the current distribution of the existing dentist population. These problems are particularly vexing for the approximately 25% of the over 65 population who live in rural areas. In our view, effective solutions to the first two problems will result in eventual resolution of the third. To accomplish these goals, however, requires a shared commitment by the public and private sectors.

The Association has long recognized its responsibility in correcting the misperceptions of dental care needs. Extensive efforts at increasing the public's understanding of dental health promotion and disease prevention include the distribution of a wide variety of patient education materials, school-based oral health education programs and public service announcements. Through these efforts and the effective use of fluorides, particularly community water fluoridation, the extent of dental caries in children has been reduced dramatically as evidenced by the 1987 National Institute of Dental Research study of caries in school-aged children.

We are now turning these successful public education efforts toward the elderly population. For example, the Association-sponsored "National Senior Smile Week" focuses attention on the importance of routine oral health care for the aging. We have also participated actively in federally sponsored programs such as Healthy Older People, the U.S. Preventive Services Task Force, Health Objectives for the year 2000, and the Surgeon General's Workshop on Health and the Aging, all of which recognize the importance of oral health in the overall quality of life experienced by elderly people. Special efforts must be made to get this message out to rural Americans through, for example, Area Offices on Aging, and senior centers.

While recognizing that the majority of our over-65 population is healthier and more financially independent than previous generations, there remains a significant percentage who depend upon public programs to finance health care services. Regrettably, dental benefits are not available through Medicare and in the Medicaid program, 23 states and the District of Columbia provide either no dental benefits to adults or limit these benefits to only extremely limited services such as emergency treatment or dentures. Clearly, adequate funds to finance needed dental care are unavailable to millions of Americans who are eligible for public health care programs.

The dental profession has voluntarily acted to reduce the financial burden to low income elderly through reduced fee programs. Currently, 43 state dental associations sponsor such programs. The private sector cannot be expected to meet this need alone. Until society, through programs such as Medicare and Medicaid, recognizes oral health to be part of general health and well-being, financial barriers will continue to plague both urban and rural elderly people.

The Association is encourged by PL 100-177 which created the the National Health Service Corps (NHSC) Loan Repayment Program. Health professionals, including dentists, who join the Corps will have their educational loans reduced by amounts up to $20,000 per year for each year of obligated service. The Association believes that this is an appropriate method of correcting maldistribution problems in the profession and for helping to alleviate access problems in rural areas that are currently underserved.

The Health Resources Services Administration, however, currently limits participation in this program to only obstetricians/gynecologists and family practitioners. The Association urges HRSA to open applications to dentists in FY 1989.

The Association also has concerns about NHSC's ability to offer long-term responses to access problems of rural Americans. In the absence of fundamental changes in perceived need for oral health care and adequate public funding for low income elderly, such programs will continue to fall short of their intended goal.

In the meantime, the Association has urged state dental associations to cooperate in identifying underserved locales and population groups. Further, we have urged that initiatives designed to meet the dental needs of underserved populations be developed jointly by state dental associations and appropriate government agencies.

The Association is gratified that the Committee is focusing on the health of the aging and in this case on the rural aging population. The Association commends to the Committee's attention oral health care as an integral part of this issue.

The basic strategies recommended here, will contribute significantly to achieving a permanent solution to the oral health needs of elderly rural Americans.

Thank you for your consideration of our views.

Item 5

AMERICAN MEDICAL ASSOCIATION
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September 1, 1988

JAMES H. SAMMONS, M.D.
Executive Vice President
(645-4300)

The Honorable John Melcher
Chairman
Special Committee on Aging
United States Senate
Dirksen Senate Office Building
Room 628
Washington, DC 20510

Re: Submission for the Record of the
Special Committee on Aging's
July 11, 1988 Hearing on Rural
Health Care Personnel

Dear Chairman Melcher:

The American Medical Association commends you and the Special Committee on Aging for your concern about the issue of attracting and retaining health care professionals in rural areas. The AMA requests that these comments be included in the record of the Special Committee's July 11, 1988 hearing on rural health care personnel.

As the Special Committee has heard already from a variety of witnesses, the difficulties in attracting health care professionals to rural areas are varied and complex and not totally dissimilar to the problems that rural areas face in attracting and retaining other services, as well as business and industry generally. Our society continues to move towards centralized urban areas where a great variety of services and opportunities exist, especially for highly trained professionals.

Specific factors may further discourage medical practice in rural areas. For example, reimbursement levels under federal health programs for physicians and hospitals in rural areas are placing increased pressures on the availability of services. In order to attract and retain physicians in rural areas it is necessary for the federal government to take steps to ensure that reimbursement practices under federal programs, including Medicare, are equitable. In addition, incentives are needed to encourage physicians and other health care professionals to locate a practice in rural areas in order to overcome this ongoing trend in demographics.

Over the years, there have been growing concerns that payment rates under federal programs unfairly discriminate against rural physicians. Geographic variations in the payment rate for physicians under Part B of Medicare and other federal programs must be carefully scrutinized on an ongoing basis to make sure that the variations in payments actually do reflect differentials in the cost for providing care. The AMA favors adoption of an indemnity fee schedule system under Medicare in which geographic differences in payment rates should reflect actual variations in practice costs. Ensuring that Medicare reimbursement reflects the cost of providing care, especially in rural areas with high percentages of elderly, is vital to helping physicians maintain practices in rural communities.

Physicians are facing increasingly high medical education expenses and indebtedness. A recent study indicates that 82 percent of all 1987 medical school graduates were in debt, owing an average of $35,621. Therefore, we urge the federal government to provide incentives, especially through service-related student loan repayment programs, to encourage physicians and other health care professionals to practice in rural areas. Such opportunities should be available at the time these individuals have completed their professional training and are [illegible] to begin practicing as professionals.

As you well know, the National Health Service Corps (NHSC) has long provided a vital resource of physicians and other health professionals for underserved rural areas. The AMA was pleased that the NHSC reauthorization passed in 1987 (P.L. 100-177) added a loan repayment program under the NHSC. Physicians and other health care professionals will be able to enter a special loan repayment program in the final year of their training or later when personal and professional goals have been determined. The difficulties of default rates and low retention rates of participants that have been experienced under the scholarship program should be greatly minimized since individuals choosing the NHSC as an option will have a better understanding of their capabilities and the circumstances they would find in an NHSC location. Congress must ensure that NHSC funding is adequate to provide physicians in areas where, because of low population density and other factors, there is an inadequate supply of physicians.

It is the AMA's experience that physicians are willing to serve in rural areas throughout their careers, even into retirement. The AMA sponsors Project USA, which recruits physicians to serve short periods of time in underserved areas under the NHSC and the Indian Health Service. Efforts to recruit practicing health professionals should not be overlooked.

A recent Rand study has shown that market forces, through increased numbers of physicians, have increased the availability of specialists in smaller cities across the U.S. While this is encouraging, many rural areas remain in need of physicians. Generally, the resource problems that rural areas have in supporting physician practices will likely continue for the immediate future.

The AMA is concerned that many individuals do not have available the best possible cost-effective medical care. For individuals who live in rural areas, access to adequate health care must be ensured through federal health care programs that encourage private practice through means such as equitable reimbursement and through programs to provide incentives that will encourage health care professionals to choose to practice in rural areas. The AMA will continue to examine the issue of physician manpower and looks forward to future opportunities to work with Congress on this important issue.

Sincerely,

James H. Sammons M.D.

James H. Sammons, M.D.

JHS/dlh
4148p

Item 6

apta American Physical Therapy Association

August 19, 1988

The Honorable John Melcher
Chairman, Special Committee on Aging
G-14 Dirksen Senate Office Building
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The American Physical Therapy Association (APTA) commends you and your committee for conducting oversight hearings this summer on an issue of concern to us, rural health care. We submit the following comments, which we request be made a part of the record of the hearings.

Physical Therapist Personnel Resources

The APTA is a national membership association representing over 48,000 physical therapists, physical therapist assistants and students of physical therapy. The practice of physical therapy involves the evaluation and treatment of musculoskeletal, neurological, pulmonary and cardiovascular systems, with the goal of restoring optimal movement and function. Many who are treated by physical therapists are geriatric patients located in rural areas.

In recent years, the demand for physical therapists has increased dramatically. Patients are being discharged from acute care facilities sooner, more people are surviving serious illness and accidents due to medical and technological advances and the elderly population, often victims of stroke, arthritis, and hip fractures, is expanding significantly. All of these patients require physical rehabilitation.

Unfortunately, providers of rehabilitation services, including hospitals, nursing homes and home health agencies are encountering severe problems in recruiting qualified physical therapists and other rehabilitation professions to provide services. A recent survey funded by the Rehabilitation Services Administration ranked the shortage of physical therapists first among rehabilitation personnel. And, these shortages are most acute in the rural areas.

The following are some statistics relating to the shortage of and demand for physical therapy personnel:

- There are an estimated 65,000 licensed physical therapists in the United States today. Of this population, 70% (45,500) work full-time, 23% (14,950) work part-time and 7% (4,550) are not working or are retired. Thus, the current work force is estimated to be 60,450.

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- o The latest Bureau of Labor Statistics, based on 1986 information, indicates that there are 61,000 physical therapist jobs in the United States; therefore, the current overall demand exceeds supply by over 500 physical therapists.
- o The Bureau of Labor Statistics also estimates the growth in jobs by the year 2000 to be at 87% (53,000 or approximately 3,800 new jobs per year). This latter figure represents the demand side of the equation and is important to bear in mind in light of the supply information that follows.
- o There are approximately 3,900 new licensees entering the physical therapy workforce per year. By the same token, there is an estimated 2.4% attrition rate from the annual work force, which represents an annual loss of about 1,451 physical therapists. This results in a net annual gain in the total work force of 2,449 physical therapists.
- o Calculating the difference between the annual growth in physical therapist jobs and the growth of the numbers of physical therapists available, our best estimates are that there will be an annual deficit in the supply/demand equation of approximately 1,351 physical therapists.
- o Additionally, this gap is expected to increase in the coming years unless efforts are made to sufficiently increase the supply to meet the growing demand.

With Congressional assistance, there are solutions to these problems. First, financial assistance is needed for the following:

- o Development, expansion and operation of physical therapy education programs to increase the number of qualified physical therapists;
- o Development, expansion and operation of post-baccalaureate and doctoral programs for physical therapy to increase the pool of qualified faculty;
- o When sufficient programs are available, scholarships in order to attract increased numbers of students for these programs.

Medicare Requirements

Two Medicare provisions, which delay access to physical therapy care for Medicare beneficiaries, need to be eliminated. Section 1833(g) of the Medicare statute provides that no more than $500 in any calendar year may be considered as reimbursable incurred expenses for outpatient physical therapy services by independently practicing physical therapists.

Physical therapy care for most illnesses and injuries requires a series of treatments rendered pursuant to a plan of care rather than a single treatment. In many cases an adequate physical therapy treatment program cannot be provided within the cost restraints now imposed by the statute. Medicare beneficiaries, therefore, are left with one of two choices. They can either discontinue treatment, with the resultant harm to their recovery, or they can seek out another provider where services must be reinitiated at increased cost to the Medicare program. This particular Medicare provision ill-serves both beneficiaries and the Medicare program.

In addition, Section 1861(p) of the Health Insurance for the Aged Act contains a requirement that where a physical therapist furnishes services on an outpatient basis exclusively in a Medicare beneficiaries' home, he must nonetheless maintain a fully-equipped office. This rule effectively hinders physical therapists from furnishing services in patients' homes because they are required to incur costs for equipment and office space which they never use. Thus, Medicare beneficiaries who are homebound or who reside in rural areas with no ready access to inpatient facilities are denied physical therapy services which they need.

We appreciate your committee's interest in rural health issues and would be happy to provide any additional information you might require.

Sincerely,

Pamela Phillips

Pamela Phillips
Associate Director, Government Affairs

Item 7

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STATEMENT

OF THE

AMERICAN PSYCHIATRIC ASSOCIATION

TO THE

SENATE SPECIAL AGING COMMITTEE

ON

RURAL MENTAL HEALTH ISSUES

The American Psychiatric Association, a medical specialty society representing more than 34,000 physicians nationwide, is pleased to have the opportunity to submit comments to the Senate Special Committee on Aging on issues related to the mental health needs of elderly Americans in rural areas and other related concerns. For the record, please also find attached a copy of an article describing mental health concerns in rural Kentucky.

Our testimony focuses on concerns about the mental health needs of elderly Americans, service delivery options, and problems facing rural Americans needing mental health services. As with all aspects of the health system, the mental health delivery system functions best for patients when prehospital, hospital and posthospital care are coordinated.

Stress in Rural Areas and Access to Services

Stress in rural areas among all segments of the population has been on the increase due to economic crises and intensification by the current drought. At the same time, problems continue in the delivery of mental health services due to environmental factors, factors related to the individualistic ethos in rural areas, confidentiality concerns, costs of care and the shortage of health professionals (Laschen, QRB, 1986).

First, the distance to facilities and providers may impede access to mental health services. Studies have shown that utilization of mental health services decreases when distance increases (Cohen, J., 1982). Coupled with distance to facilities is the dispersion of population base which can produce problems in providing specialized mental health services. Second, because independence is the *modus operandi* of many rural residents, their cultural and attitudinal approaches to mental health problems may attenuate, and in fact prevent individuals from seeking care until a crisis develops. Third, the professionals serving communities may know their patients as friends and sometimes relatives. Stress on mental health professionals may be greater than in urban areas as they may treat their own family members and have few other professionals with whom to work. Confidentiality becomes essential, and yet, because a psychiatrist may treat a relative or a friend, others may expect information to be released. Fourth, with fewer patients the cost per unit of delivering mental health services may be greater and in particular, costs to travel to a facility, telephone costs etc. are all subject to diseconomies of scale. One study reported that travel costs may rise as high as $50,000 a year (*Hospital and Community Psychiatry*, Sept. 1977). Fifth, shortages of psychiatrists and other mental health professionals exist in many rural areas.

In order to address concerns about rural stress, Congress has funded rural mental health demonstrations (described below) and various conferences and hearings were held even prior to the Special Aging Committee hearings. Concerns about the mental health of rural American families resulted in 1986 hearings held by Senator Durenberger in Minnesota and in a Rural Stress Policy Forum conducted by the National Institute of Mental Health in the Spring 1986 in Chicago, Illinois. Attendees at that NIMH conference included key government officials, national organizations, providers and researchers. Both the hearing and the forum found increased utilization of mental health services, and increases in suicide and suicide attempts in rural areas.

Studies reported at the NIMH Policy Forum on Rural Stress demonstrated the increasing mental health problems in rural areas. From the studies conducted on younger populations, we can infer some of the problems the elderly may be facing. First, research at the University of Minnesota in three Minnesota communities documented the increasing stress, depression, and suicides in the adolescent population. Depression was approximately two times the national average in the 15-19 year old population. Out of every 100 adolescents surveyed, three had attempted suicide in the month preceding the survey. In addition to self-reported depression, on a standardized measure of depression (Beck scale), adolescents living in rural homes had higher average Beck depression scale scores than adolescents hospitalized at the UCLA Neuropsychiatric Institute. Compared to a similar study in New York twice the number of adolescents were moderately or severely depressed.

Second, a study conducted at the University of Missouri examined farm families forced out of farming for financial reasons. All women and the majority of men in the 42 families studied indicated they had experienced depression at some time during the course of the financial problems with their farms. Many (over half the men and 3/4 of the women) continued to experience depression even after some settlement was reached. Increased substance abuse, withdrawal, and physical aggression were also noted.

Estimates of mental health problems of the elderly indicate that 15 to 20 percent — between 3 and 5 million — of our nation's more than 25 million elderly Americans have significant mental health problems. In addition, twenty to thirty percent of older Americans labeled "senile" actually have reversible, treatable conditions. It is well recognized that general assaults on the self esteem of elderly people put them, in general, at significant emotional risk. This is evident in the fact that in 1982, individuals over age 65 accounted for 10% of the population, but 17% of deaths by suicide. Additional financial problems in rural areas and the self-sufficiency of elderly individuals may produce extreme stress, but the self-sufficiency of rural Americans and the dispersion of services may result in a unwillingness to seek service until mental health problems produce a major crisis. Estimates also indicate that the elderly population receive as much as half of all prescribed barbituates and sedative medication. Given that the population of elderly rural Americans has grown 30% since 1960 (while the general rural population has grown 10%), it is probable that the need for use of mental health services including hospitalization has also increased significantly. Congressional expansion of the Medicare mental health benefit in 'OBRA '87 (PL 100-203) is a large step on the road toward nondiscrimination against the mentally ill.

In addition to the statistics cited above, one study conducted at Kansas State University found that between 12 and 23% of a mostly rural elderly population showed significant psychiatric symptomatology (Scheidt and Windley). Thousands of elderly people in 18 small towns (not all of which were rural) located in rural counties were interviewed and administered three standardized scales (Langer screening scale, Bradburn affect Balance Scale, Philadelphia Geriatric Morale Scale). Fifteen - twenty percent of the study group demonstrated psychiatric problems on the standarized scales. Only one percent of this frail elderly population had sought mental health services for their concerns. Many of the elderly people interviewed had physical as well as emotional problems and felt isolated from family and friends.

In fiscal year 1987 Congress allocated $1,200,000 to the National Institute of Mental Health to establish four Rural Mental Health Demonstrations to assist States to promote the community development of comprehensive mental health, health, job retraining, employment and related services for rural Americans experiencing serious emotional and behavioral problems. Four states (of an eligible 13) were awarded grants (Nebraska, Minnesota, South Dakota and Iowa). The four States differ widely in their approaches and are just beginning the implementation phase. ABT Associates will evaluate the demonstrations.

Availability of Selected Services in Rural Areas

Data from the American Hospital Associaton's 1984 Annual Survey of hospitals indicates that in non-SMSA areas of the country, there are a total of 13,320 beds for psychiatric acute care (less than 30 days), and 12,987 beds for psychiatric long-term care (over 30 days). In addition, there are 4,142 Acute care alcohol/chemical dependency beds and 1,546 long-term alcohol/chemical dependency beds in 2,937 hospitals in registered hospitals. The total beds for these services are approximately 14% of rural beds and may not be adequate given the tremendous needs of rural residents. 304 hospitals provide acute psychiatric care and 54 provide long-term psychiatric care. One hundred fifty-six hospitals provide acute alcohol/chemical dependency services and 51 provide long-term alcohol and chemical dependency services.

Because the majority of hospitals are not dedicated psychiatric facilities, one must examine service delivery capability in these hospitals. Kiesler and Sibulkin (1984) report on the disparity of data for the episodic rate of mental hospitalization. Although the rate of hospitalization has remained stable (1.8 million) in recent years in psychiatric hospitals, admissions for psychiatric inpatient episodes in general hospitals increase the total to 3 million, thus, indicating a steady increase in hospitalization rates for mental health episodes from 1966 to 1979. Discharges from general hospitals without psychiatric units occur much more frequently than discharges from hospitals which have distinct-part psychiatric units. (This fact may be even more apparent in rural areas). One study compared the number of people receiving services in the specialty mental health sector versus the general mental health sector. Psychiatric units in general hospitals accounted for over 30% of the inpatient episodes, however, there were twice as many inpatient episodes in general hospitals without psychiatric units (Regier et. at. 1978; Taube et. al. 1978).

While AHA data theoretically would exclude "scatter beds" from definitions of services delivery, it is possible that some of these programs listed may, in fact, be scatter beds, as hospitals self-reported service delivery and some scatter beds, in fact, may represent organized programs but not units per se. Very little is known about scatter beds except that patients admitted to these beds have shorter lengths of stay (7.9 days) than those admitted to separate units (17 days). Their diagnoses are more frequently alcoholism and neuroses, in contrast to diagnoses of schizophrenia and personality disorders in psychiatric units; and the patients tend to be older and represent a higher percentage of men than those admitted to psychiatric units (Kiesler and Sibulkin, 1983). Services provided to these patients are not well-documented, however, one rural area created a scatter bed program because there were not sufficient resources to set up a separate unit (Werner, Knorr and Stack 1977-78).

Lenox Hill Hospital in New York formulated a detailed and formal protocol for a scatter bed program in 1978. Findings from the program indicated that patients with mixed psychiatric medical diagnoses were most appropriate for those scatter beds, but individuals with substance abuse were inappropriate. By using a formal screening system, clinically appropriate patients were admitted to the unit in a manner consistent with the openness of the unit (Colline and Skiest).

Because the potential for existence of scatter beds is large in rural areas, questions may be raised about the extent to which organized programs exist and the extent to which access to the appropriate hospital treatment modality is available in rural areas. Well-organized scatter bed programs may provide appropriate psychiatric supervision for patients, but less formal programs may have questionable quality of care for the treatment of mental illness.

Rural hospitals are more likely to be financially vulnerable because of fluctuations in case mix and volume (PROPAC Report to Secretary of HHS, April 1986). Patients with mental illness problems in rural areas are also likely to be more vulnerable. Service delivery may be more regionalized, and yet recuperation from mental health problems may require family support.

Patients may seek out psychiatric services only when they are having a crisis or they may not know how to seek out these resources when needed. Some problems psychiatrists have noted include:

1) In a rural community in Texas (25,000 people), one psychiatrist covers five counties. There is one 12 bed inpatient psychiatric unit. Slowdowns in payments to the psychiatrist (member of multi-specialty group with 40% Medicare patients) and to the hospital are a significant problem. Rural hospitals cannot bear the financial risk of inconsistent payment.

2) In a rural area of Michigan, the nearest psychiatric hospital was 100 miles away and the nearest state mental hospital was 200 miles away. When hospitalization is required for major disorders, (not possible to handle in a general unit) there is significant disruption for elderly beneficiaries and their families and potential for further alienation of the elderly patients.

3) In some cases, while partial hospitalization or day treatment may be appropriate treatment modalities, distance from a facility in rural areas may be so great (and Medicare coverage so poor), that the only choice would be to hospitalize a patient.

4) Some rural areas of the country do not have a psychiatrists who can cover a rural inpatient psychiatric unit.

5) One state has delayed the transfer of designation of certain hospital units as psychiatric units, because of delays in developing a state health plan. Because of these delays, appropriate well-staffed units cannot be developed.

Reports from psychiatrists in rural areas also indicate that the distances from the facilities in rural areas has, at times, resulted in situations where community mental health service follow-up is hard to implement on a consistent basis.

A 1982 APA survey of active psychiatrists documents the need for expanded training opportunities in rural states. In terms of the supply of psychiatrists, rural states generally have lower number of psychiatrists per 100,000 population. For example, in 1982 there were 12.9 psychiatrists per 100,000 on average across the nation, but in Idaho there were 3.7 psychiatrists per 100,000 physicians, and 4.7 psychiatrists per 100,000 persons in Montana. (Please see attachment).

Summary

As the Senate Special Aging debates issues related to rural health concerns it is our hope that you will address the mental health needs of elderly rural Americans. Simple solutions to problems with the supply of professionals, including psychiatrists, in rural areas are not warranted. Suggestions, such as allowing non-physician providers to prescribe drugs, only serve to denigrate our patients with mental disorders and reinforce their status as second class citizens. Our rural elderly citizens face grave problems, which need comprehensive solutions. The federally funded demonstrations may provide some suggestions for the future.

ATTACHMENT A

Rural Stress/*Growing Depression*

By Jay B. Cutler, J.D.
Special Counsel and Director of Government Relations
Ellen S. Smith, M.B.A.
Assistant Director of Government Relations
American Psychiatric Association

Agriculture's plummeting economy has so stressed rural Americans that there has been a 30 percent increase in the number of people seen for outpatient mental health services. One 24-hour drop-in crisis center has a 330 percent increase in patients.

Compounding increased family financial and emotional stress is a lack of health insurance in rural America. Even those with insurance may have inadequate coverage for mental and addictive illnesses.

As pressures on rural Americans drive them closer to the emotional brink, pressures to contain health care costs may be driving people away from the mental health care they need. Coverage policies of Medicare and private insurers frequently do not allow sufficient hospitalization for the mentally ill. For instance, under Medicare, hospitalization in psychiatric beds is limited to a 190 day lifetime maximum — not the "spell of illness" concept common to other medical disorders.

Chronic mental illness is unique. It is not a one year illness. A young Medicare schizophrenic beneficiary may need intermittent treatment for thirty or forty years.

While there is an incentive to use outpatient services for other medical diseases, Medicare has a $250 a year — after copayment and deductible — limit on outpatient psychiatric services. The limit, along with the stigma against mental illness, may discourage people from seeking care.

Rural depression continues to grow. The University of Minnesota has found increasing stress, depression and suicides in adolescents. Depression was approximately two times the national average among 15-19 year olds. Out of every 100 adolescents surveyed, three had attempted suicide in the past month. Other studies show rural adolescents had higher depression scale scores than adolescents hospitalized at the UCLA Neuropsychiatric Institute. Compared to a similar study in New York, twice the number of rural adolescents were moderately or severely depressed.

A University of Missouri study found all the women and most of the men in families forced out of farming by finances were depressed during their financial difficulties. Half of the men and three-fourths of the women continued to be depressed after some financial settlement was reached. Increased substance abuse, emotional withdrawal, and physical aggression was noted.

Between 15 and 20 percent of the rural elderly — 3 to 5 million people — have significant mental health problems. And, 20 to 30 percent of older Americans labeled senile actually have reversible, treatable conditions.

In general, the elderly are at significant emotional risk. In 1982, people over 65 accounted for 10 percent of the population but 17 percent of the suicides. Financial problems in rural areas and the difficulty of maintaining self-sufficiency may produce extreme stress. The tendency of the rural elderly to try to remain self-sufficient and lack of services results in an unwillingness to seek help until there is a crisis.

The elderly receive as much as half of prescribed barbiturates and sedative medication. Given that the elderly rural population has grown 30 percent since 1960, the need for mental health services, including hospitalization has increased significantly.

The University of Kansas State found that between 12 and 23 percent of a mostly rural elderly population showed significant psychiatric symptoms. However, only one percent of the frail elderly population studied had sought mental health services. Many also had physical as well as emotional problems and felt isolated from family and friends.

Despite the need, there are not enough psychiatric beds to serve the rural people. The American Hospital Association's 1984 annual survey of hospitals indicates that in non-metropolitan areas, there were 13,320 beds for psychiatric acute care (less than 30 days), and 12,987 beds for psychiatric long-term care (more than 30 days). Also, there were 4,142 acute care alcohol or chemical dependency beds and 1,546 long-term alcohol or chemical dependency beds in 2,9[illegible]7 hospitals. Combined, this amounted to about 14 percent of rural hospital beds. This may not be adequate given the tremendous rural needs.

In Kentucky, in 1984 there were 171 acute psychiatric beds, and 10 acute alcohol and chemical dependency beds in non-metropolitan areas. Of the 77 non-metropolitan hospitals in Kentucky in 1984, ten provided acute psychiatric services and one provided alcoholic and chemical dependency treatment units. Nineteen of these hospitals offered acute psychiatric services; seven offered outpatient services, four offered partial hospitalization, fourteen offered emergency services, and one offered foster or home care.

Many hospitals that do not have facilities dedicated to psychiatric treatment may, however, deliver some services. Although the rate of admissions to psychiatric hospitals has been stable in recent years, admissions to general hospitals for psychiatric episodes have increased.

Some of the programs listed by AHA may be actually scatter beds rather than units. Little is known about scatter beds except that patients admitted to them have shorter lengths of stay (7.4 days) than those admitted to separate units (17 days).

Patients in scatter beds are more often

Continued

Stress/Depression (continued)

diagnosed for alcoholism and neuroses. Schizophrenia and personality disorder predominant in psychiatric units. Patients in scatter beds tend to be older.

Findings of Lenox Hills Hospital in New York indicate patients with mixed psychiatric/medical diagnoses were most appropriate for those scatter beds. People with substance abuse problems were not.

In 1982, there were 12.9 psychiatrists per 100,000 people nationwide. Kentucky had 7.2, ranking 36th. That means 265 or .9 percent of the nation's psychiatrists were in Kentucky. More recent data suggests that there are now more than 300 licensed Kentucky [illegible]hiatrists

Many rural communities have only one psychiatrist. Some have none. Few of Kentucky's psychiatrists were in rural areas.

This puts more pressure on the rural psychiatrist who may be the only psychiatrist in the area. The psychiatrist must be a generalist. Other physicians may not know when to refer to the psychiatrist. The psychiatrist may have no support group and may treat friends and relatives — a stressful situation.

Here are some examples of the problems:

- In a rural community in Texas, one psychiatrist covers five counties. There is one 12 bed psychiatric unit. Slowdowns in payments to the psychiatrists and to the hospitals are significant problems. Rural hospitals cannot bear the financial risk of inconsistent payment.
- In a rural area of Michigan, the nearest psychiatric hospital was 100 miles away and the nearest state mental hospital was 200 miles away. When hospitalization is required for major disorders, there is significant disruption for the elderly patients and their families and the potential for further alienation of the patient.
- Sometimes, while partial hospitalization or day treatment may be appropriate, distance from the hospitals may be so great, and Medicare coverage so poor, that the only choice is hospitalization.
- Some rural areas do not have a psychiatrist who can cover a hospital scatter bed program or a rural inpatient psychiatric unit.
- In some rural areas of Kentucky, patients who need day treatment may only receive the appropriate services one or three times a week.
- Reports from rural psychiatrists indicate that the distance from the hospital has often resulted in difficulty for consistent patient follow-up.

Rural hospitals are often financially vulnerable. Mentally ill patients in rural areas are also likely to be vulnerable. Service may be regionalized. Yet, recuperation may require family support.

Because of concerns about financial security, Congress created special exceptions for rural referral centers and sole community providers. Since 1984, six Kentucky hospitals were declared sole community providers and seven were rural referral centers. Two are both. Sole community hospitals receive 75 percent of the hospital's actual costs and 25 percent of the federal diagnoses related group rate. Regional and national referral centers are paid at an urban rate.

The Omnibus Budget Reconciliation Act of 1986 includes a provision to establish a separate threshold percentage for low-income patients at rural hospitals with 500 or more beds and a disproportionate share of low income patients. Periodic interim payments will also be retained for hospitals with fewer than 100 beds.

Increasing demand from two competing forces are likely to continue. Difficult economic situations produce greater need for psychiatric services for the elderly and the whole population. But, cost containment could force hospitals to close, reduce the range of services, or treat people, within the range of acceptable medicine, as quickly as possible. Creative planning for programs and fiscal affairs is needed to protect the delivery of services to the mentally ill and the financial health of rural hospitals.

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ATTACHMENT B

NUMBER OF ACTIVE PSYCHIATRISTS BY RATE PER 100,000 POPULATION[1] AND RANKING BY STATE: 1982

STATE	N	RATE	RANK
Total, United States	29791	12.9	--
Alabama	196	5.0	46
Alaska	40	9.1	25
Arizona	279	9.8	23
Arkansas	126	5.5	44
California	4483	18.1	5
Colorado	488	16.0	8
Connecticut	771	24.4	3
Delaware	83	13.8	10
Florida	1060	10.2	22
Georgia	508	9.0	27
Hawaii	172	17.3	7
Idaho	36	3.7	50
Illinois	1240	10.8	20
Indiana	314	5.7	43
Iowa	168	5.8	42
Kansas	310	12.9	13
Kentucky	265	7.2	36
Louisiana	358	8.2	31
Maine	124	10.9	19
Maryland	1032	24.2	4
Massachusetts	1640	28.4	1
Michigan	1080	11.9	16
Minnesota	326	7.9	32
Mississippi	117	4.6	48
Missouri	463	9.4	24
Montana	38	4.7	47
Nebraska	111	7.0	37
Nevada	68	7.7	33
New Hampshire	115	12.1	15
New Jersey	1025	13.8	11
New Mexico	140	10.3	21
New York	4958	28.1	2
North Carolina	540	9.0	29
North Dakota	42	6.3	39
Ohio	973	9.0	26
Oklahoma	194	6.1	40
Oregon	294	11.1	18
Pennsylvania	1639	13.8	9
Rhode Island	131	13.7	12
South Carolina	236	7.4	35
South Dakota	41	5.9	41
Tennessee	318	6.8	38
Texas	1300	8.5	30
Utah	118	7.6	34
Vermont	93	18.0	6
Virginia	706	12.9	14
Washington	477	11.2	17
West Virginia	105	5.4	45
Wisconsin	428	9.0	28
Wyoming	22	4.4	49

Source: APA 1982 Manpower Report, Pending Publication, 1986.

[1] State population estimates were taken from U.S. Bureau of the Census, Current Population Reports, Series P-25, #944. Physicians practicing in the District of Columbia were excluded from the APA Manpower Report and will be included in a future supplementary report of psychiatrists in large metropolitan areas.

SOURCE: ECONOMIC FACT BOOK OF PSYCHIATRY 1987

Item 8

American
Psychological
Association
Advancing psychology as a science, a profession, and as a means of promoting human welfare

TESTIMONY OF

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

Offered by

Leonard D. Goodstein, Ph.D.
Executive Vice President & Chief Executive Officer

before the

UNITED STATES SENATE'

SPECIAL COMMITTEE ON AGING

on the subject of

RURAL HEALTH CARE CHALLENGES, PART II
RURAL HEALTH CARE PERSONNEL

The American Psychological Association, on behalf of our 90,000 members, is pleased to present this statement as part of the record of the Special Committee on Aging's hearing on Rural Health Care Personnel. We commend Chairman Melcher and the members of the Committee for their commitment to improving the health care of older rural Americans and to examining the personnel issues pertaining to their care.

Our testimony will focus on several areas: the mental health care needs of older adults living is rural areas, the inadequacies of the current mental health delivery system, including personnel issues, and recommendations to improve care to our older citizens.

Mental Health Care Needs of Older Rural Americans

The 1980s have been a time of great financial and social hardship for rural Americans; there have been foreclosures on family farms, a decrease in demand for domestic petroleum, losses in the lumber industry, increased international competition for the textile industry, and and mine closings. With the deteriorating economic conditions have come increased personal and family stress, increased incidence of child abuse, increased alcohol abuse, a higher incidence of anxiety and depression, and poorer health and mental health care as insurance benefits are depleted. These are circumstances which effect all members of the family, the young as well as the old.

In addition to these circumstances which effect many rural residents, research supported by the National Institute of Mental Health, the National Institute on Aging, the Veterans Administration, the Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging, and many others, we have learned a great deal about the mental health of older persons and their psychological and behavioral problems, about the utilization (or non-utilization) of psychological services by the aged, and about the current nature of the unmet needs for psychological support and services among the aged.

Current estimates suggest that there are approximately 26 million persons age 65 or older in the United States (about 12 percent of the national population, and that their concentration in rural, suburban, and urban areas vary widely from state to state and within states. While most of these individuals are emotionally healthy, it has been estimated that 10% to 28% of older Americans living in the community (2.6 to 7.3 million individuals) have mental disorders serious enough to warrant professional attention. Unfortunately, it has also been estimated that over 80% of the elderly in need of mental health services will not receive them.

Older persons who are in need of mental health services are a heterogeneous population, but may be grouped into three broad categories. These categories represent different etiological factors for the mental health disorders and may represent different service needs. First, individuals with a history of chronic mental impairment who have reached old age. The predominant mental disorders in this category include: schizophrenia, severe depression, severe character disorders, and chronic addictive disorders. Many of these individuals were once residents of state psychiatric hospitals, but were transfered to nursing homes and board and care facilities during the deinstitutionalization movement begun in the 1960s. Some have become homeless persons, living in shelters or in single room occupancy facilities. These older individuals are sometimes participants in senior centers and nutritional sites.

The second category includes older persons who develop mental disorders in later life, with no prior history of mental impairment. The predominant disorders in this category include anxiety disorders, dysporia and major depression, social withdrawal, poly drug use and misuse (and confusion about) prescription drugs, alcohol abuse, organic brain syndrome, and dementia (including Alzheimer's disease). With this category there is concern about suicide, as men over the age of 75 have the highest rate for all age groups. Persons in this category are more likely to reside in the community and be cared for by their family, and some are residents of nursing facilities.

The third category includes individuals with mental disorders associated with physical health disorders. Examples of disorders in this category include severe anxiety associated with gastrointestinal complications, hearing loss that may lead to delusions and social withdrawal, and cardiac disease and depression. The interaction between mental disorders and physical illness in the elderly is only beginning to be understood, and is a focus of continuing research.

In addition to the three categories noted here, many mental health professionals believe that older persons could also benefit from mental health services oriented toward helping them cope with circumstances that are known to contribute to the development of disorders, such as stressful living conditions, social isolation, bereavement, acute and chronic health conditions, and the burden of serving as a caregiver to a severely impaired family member.

Older persons with mental disorders differ from other age groups in that they are more likely to have multiple comorbidies. The aged may have overlapping and interdependant medical, social, behavioral, and mental health problems, requiring the attention and coordination of service systems as well as service providers.

Older Persons Are Not Adequately Served by the Mental Health System

Research and clinical experience have demonstrated that older persons do respond well to appropriate psychotherapeutic, psychopharmacological, behavioral, and social interventions, and that these interventions can often be effectively provided on an outpatient basis. Unfortunately, older persons rarely receive the mental health services they need. This is true for both the public and private mental health systems and is true for both rural and urban areas.

The pattern of inadequate mental health services to older persons persists as a result of a combination of factors: reimbursement structures under federal health programs; a reduction of federal mental health funding under the Alcohol, Drug Abuse and Mental Health Services block grant; the continued fear and stigma that still haunt our national conception of mental disorders; the fragmented, disorganized system of mental health, physical health, and social service programs for the elderly; the lack of available mental health personnel to provide services to older persons; and the problems inherent in delivering services in many rural areas — the great diversity in cultures and language, racial and ethnic groups, occupations, lifestyles, and physical geography and isolation.

The Role of Psychologists in Geriatric Mental Health Care

The mental health problems require the expertise of appropriat trained personnel. The unique contribution of a psychologist is ser to the predisposing causes underlying the problems that are not biol in nature, but rather may be behavioral, psychological, or social in c Training which focuses on the understanding of the individual in the context of life situations and personal environment, allows the psychologist to provide mental health services to the elderly by means of psychological assessment, psychotherapy, behavioral and cognitive therapy, biofeedback, education, and consultation. More specifically, with regards to treatment, psychologists contribute to the optimizing of personal autonomy and integrity by teaching coping skills, providing counseling around predictable life crisis, maximizing the fit between individual and environment by means of environmental design, and by identifying social-economic system factors which exacerbate mental disorders.

Psychologists provide geriatric services in many settings, including mental health clinics, rural health clinics, hospitals, nursing homes and other long-term care facilities, senior centers, and hospice programs. In addition, over 1400 psychologists are on the faculty of medical schools, providing training to future physicians.

Mental Health Personnel Issues in Rural Areas

Our testimony will focus on three personnel issues: the availability of mental health personnel needed to provide services to older persons in rural areas, the training of mental health professionals, and problems of recruitment and retention of personnel.

The availability of psychologists. In 1988, the American Psychological Association provided estimates to the National Institute on Aging on the number of psychologists currently needed to provide services to older persons and the projected number needed by the year 2020, a short 32 years from now. Research conducted in the late 1970s indicated that the number of psychologists trained to provide geriatric services was woefully inadequate to meet the mental health needs of the aged. More recent data, from the early 1980s, suggests that this situation has not markedly improved, given the number of elderly in need of services and the reduction in federal support for psychology training programs and for mental health services. There are approximately 2000 psychologists who have older persons as half of their clinical caseload. We estimated that 5,000 psychologists will be needed to provide services to the aged by the year 2020. Not only are there an insufficient number of psychologists (and other mental health professionals) to provide services to the current cohort of elderly, there aren't a sufficient number of students being trained to adequately provide the services which are anticipated will be needed by the increased number of older persons in the future.

Older persons in rural areas have a double jeopardy when it comes to receiving mental health services. First, there are fewer mental health personnel available in rural areas to provide mental health care. And while the ratio of practitioner to population may not be vastly different from some suburban areas, the distances to be traveled in rural areas to reach services are often considerable. Second, most mental health practitioners have not received training in providing services to a geriatric population (this is true across the health professions) and, thus, do not fully understand the multifaceted needs of older persons. Research conducted by the Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging found that as a result of the decrease in federal support for community mental health centers, under the Alcohol, Drug Abuse and Mental Health Services block grant, that geriatric programs were often discontinued and geriatric service staff were either transferred to other programs or terminated due to a reduction in force.

The training of mental health professionals. As mentioned, there are not enough students being trained to provide mental health services to older persons. The reasons for this include the substantial reduction in federal support for the National Institute of Mental Health's Clinical Training Program, which includes aging as one of its priority areas. There has been a decline in support for this crucial program over the last seven years, from $61.9 million in FY 81 to 16.8 million in FY 88. In addition, the Minority Fellowship Program, which was developed to provide training to minority students, was funded at only $1.1 million in FY 88.

Recruitment and retention of mental health professionals. The recruitment and retention of mental health professionals are often problems in rural areas. Positions that psychologists often assume in rural areas are in community mental health centers, colleges and universities, establishing a private clinical and consulting practice, or a combination of these professional activities. With reductions in federal support for community mental health centers and a decrease in available academic positions, job opportunities for psychologists have decreased in some rural areas. In addition, there are problems regarding Medicare and Medicaid. Medicare Part B outpatient mental health benefits are limited and psychologists are not directly reimbursable for their services. Thus, there is a financial disincentive for older persons to seek the services of a psychologist in independent practice. The lack of Medicaid supported mental health services in nursing homes not only denies needed services to the residents of these facilities, but denies job opportunities to mental health professionals who would be attracted to rural areas to provide these services.

The American Psychological Association strongly supported the provision in the Omnibus Budget Reconciliation Act of 1987 which provided that, as of July 1, 1988, therapy provided by a clinical psychologist will be reimbursed if provided in rural health clinics or community mental health centers. While it is too soon to determine the impact of this legislation on the availability of psychologists in rural areas, our anticipation is that it will be of benefit to rural communities, including older residents.

Recommendations

To address the problems we have raised, the American Psychological Association makes the following recommendations:

1. That community mental health and rural health care clinic funding be increased and that funds be targeted for services to older persons. In addition, we propose that funding be done on a multi-year basis to provide stability and allow for program planning. There has been considerable variation among states in the quantity and types of services provided for the elderly, and the fluctuation in federal support provides little incentive for the development of innovative service delivery programs designed to meet the mental health needs of older persons. Increased and targeted funding would not only provide for improved mental health services to older adults, but would allow for the hiring of staff trained in geriatric mental health.

2. That psychologists be included for direct reimbursement for outpatient mental health services under Medicare Part B. Out patient mental health benefits were increased under the Omnibus Budget Reconciliation Act of 1987, but only psychiatrists can be directly reimbursed for providing these services under current law. Including psychologists for direct reimbursement will allow older persons freedom of choice in who to go to for care, and will greatly improve access to high-quality mental health services for older adults.

3. The federal government should ensure that present and future geriatric mental health personnel needs are being met through clinical and research training programs supported by the Department of Health and Human Services, the Veterans Administration, and other Departments and agencies that serve older persons. The shortage of mental health personnel trained in service delivery constitutes a critical national problem, and, therefore, must be addressed at the national level. Concerted efforts are needed to training both students and faculty in geriatric mental health services. Clinical training, program development, and faculty development funds should be used by professional schools and departments to: (a) insure that the core education of all students includes a greater focus on the problems of older persons, (b) develop a greater number of specialized courses in geriatrics, (c) expand supervised practicum opportunities in geriatric mental health service delivery (particularly in rural areas), (d) expand continuing education opportunities in mental health services to older persons, (e) increase support for the Minority Fellowship Program in training minority students to work with the aged, (f) encourage mid-career respecialization in geriatrics, and (g) increase the number of new faculty with expertise in aging within professional departments.

As research increases our knowledge of the aging process and associated physical, psychological, and mental health factors, it is important that research training opportunities in geriatrics and gerontology also be vigorously supported through grants, training fellowships, and career development awards.

Item 9

ASAHP
Vanguard of the
Allied Health Movement

**American Society
of Allied Health Professions**

1101 Connecticut Avenue, N.W., Suite 700, Washington, D.C. 20036 202/857-1150

July 25, 1988

The Honorable John Melcher (R. MT)
Chairman, Special Committee on Aging
Dirksen Senate Office Building, SD-G41
Washington, D.C. 20510

RE: Rural Allied Health Care Personnel

Dear Senator Melcher:

On behalf of the Board of Directors and members of the American Society of Allied Health Professions, we are pleased to submit the attached testimony for your serious consideration as you and the Special Committee on Aging deliberate on the critical issues impacting rural health care for our aging population.

We applaud you and the members of your Committee for recognizing the role of the allied health professions in the delivery of health care to our rural aging. Please let us know how we may further support your efforts in addressing allied health personnel and allied health education in meeting the needs of rural America.

Sincerely,

Thomas E. Freeland, Ph.D.
President

Carolyn M Del Polito

Carolyn M. Del Polito, Ph.D.
Executive Director

TEF/CMDP/cm

cc: ASAHP Board of Directors

TESTIMONY

OF THE

AMERICAN SOCIETY OF ALLIED HEALTH PROFESSIONS

REGARDING

RURAL HEALTH CARE PERSONNEL

Mr. Chairman and Members of the Select Committee on Aging:

On behalf of the American Society of Allied Health Professions (ASAHP), we are most pleased to submit our comments for the record on the important issues related to health care personnel in rural America--particularly as they relate to allied health personnel serving the needs of an aging population.

The American Society of Allied Health Professions (ASAHP)* is a national nonprofit scientific and professional organization serving the needs of allied health educators, practitioners, professional institutions and organizations, and others whose mission is to improve health care by enhancing the effectiveness of education for allied health professionals. ASAHP has as its ultimate goal the best possible training and utilization of all allied health professions.

THE ALLIED HEALTH WORKFORCE

Over three million health care professionals comprise the allied health workforce (64% or six out of every ten health care workers), providing services in all health care settings, including rural communities, (e.g. hospitals, clinics, hospices, extended care facilities, community programs, and schools). Allied health professionals share responsibility for the delivery of health care services, including: services related to the identification, evaluation, and prevention of diseases and disorders, dietary and nutrition services; health promotion services, rehabilitation services, and health systems management services.

The allied health professions include a wide range of disciplines such as audiology, dental hygiene, dietetics, EKG/EEG technology, medical records administration, medical technology, microbiology technology, nutrition, occupational therapy, physical therapy, radiologic technology, respiratory care, speech-language pathology, surgical technology, and others.

Along with over 1,000 individual members, the Society serves and represents a constituency of 20 professional organizations (whose members total approximately 350,000 professionals in related services), and 120 collegiate schools of Allied Health, containing close to 1,500 allied health educational programs and graduating approximately 40,000 professionals each year. (Graduates of the allied health sciences account for as many as 1 out of every 6 graduated from higher education institutions listed by the U.S. Department of Education).

THE CRISIS IN ALLIED HEALTH PERSONNEL

Although more than 8,000 active programs prepare allied health practitioners, with more than half of all colleges and universities in the United States housing one or more of these programs, little is known about how to best direct this enormous education and training resource to meet the needs of our rapidly growing elderly population (Journal of Allied Health, November 1987). Reports from both the Office of Technology Assessment and the US Public Health Service have concluded that allied health students are not being prepared in sufficient numbers to treat the rapidly growing population. Indeed, severe shortages are evidenced across the professions. The Office of Technology Assessment report was particularly critical of the availability of information regarding geriatric specialization among allied health professionals.

Not only are there severe shortages in the allied health workforce, but also clear evidence of a seriously shrinking applicant pool. The first page of a November 1987 issue of American Medical News identifies the shortages in allied health as a "manpower crisis," noting the growing labor shortage in all areas of allied health is "crippling hospitals across the nation." The impact on rural hospitals is particularly evident.

Projections indicate that "between the years 2020 and 2030, 75 percent of health providers' time may be spent providing services to the elderly . . . .Over 65 percent of allied health professionals will be employed outside the hospital, in home- and community-based settings where older patients predominate." So stated the American Society for Allied Health Professions' (ASAHP) National Task Force on Gerontology and Geriatric Care Education in its recently-released report, "An Aging Society: Implications for Health Care Needs--Impact on Allied Health Practice and Education."

As evidenced in reports of the American Medical Association, the American Hospital Association, the American Society of Allied Health Professions, the Veterans Administration, the Institute on Aging, the Institute of Medicine, the Department of Health & Human Services, and in presentations to the National Council on Health Professions Education, the shortage of qualified allied health personnel (as in nursing) is well upon us, and it is clear that by the year 2000 there will be an even greater demand for allied health professionals. Specifically, shortages for occupational and physical therapists, speech language pathologists, and audiologists have been identified as even more severe than those in nursing. According to the latest information from the U.S. Bureau of Labor Statistics, the demand for physical therapists and radiological technologists is projected to rise 87 percent and 65 percent respectively from 1986 to 2000. The demand for occupational therapists will grow 52 percent, for physical therapy aides 82 percent, and laboratory technologists 24 percent, all by the year 2000. The impact in our rural areas will be even greater. Other areas where severe shortages will be evidenced are in dietetics, dental hygiene, and medical records administration. Such shortages will surely impact the provision of quality care to all Americans, and particularly our aging population.

The causes of these shortages are multiple and complex. New service delivery settings, (e.g., long-term care, home care), reimbursement policies, demographic changes, and economic pressures are having negative effects on future growth rates for the professions that comprise this workforce. Primarily, the shortages are a result of:

- An increasing aging population with increased demand for services;
- An AIDS epidemic with 50,000 infected and hundreds of thousands with HIV at risk in the future; which not only increases demand for service but acts as a deterrent for those choosing health careers;
- Fewer women entering the allied health professions because of increased career opportunities with higher salaries;
- Severe faculty shortages in key disciplines such as physical therapy and occupational therapy, caused by better economic conditions outside academia; and
- Little or no federal attention or financial support for the education of allied health professionals since 1980.

ALLIED HEALTH PROFESSIONS: SERVING AN AGING POPULATON IN RURAL AREAS

The allied health professions now make significant contributions to elder care, but the untapped potential they represent is even more remarkable--particularly in rural areas. Shifting demographic patterns, increasing use of long-term care facilities, improving access to health care for older persons, and growing utilization of a broader variety of allied health services have all caused the National Commission on Allied Health Education to conclude that allied health professionals will be increasingly in demand, both in institutional and noninstitutional settings. Providing health care services for the rural elderly is exacerbated by the increased number of elderly in rural areas, who generally require more health care services.

Employment statistics suggest that about two thirds of allied health personnel work in settings other than hospitals; i.e. nursing homes, private group practices, and home care. Moreover, nursing and allied health professionals hold the largest professional market share in home health care, a burgeoning industry.

Yet, the quality and variety of services provided to the elderly in rural America are severely diminished by the lack of adequately trained health workers to provide these services. In many areas, nurses, LPNs, and others who are untrained and unqualified are providing "allied health services," severely affecting the quality of care given. Even basic oral hygiene services are often neglected with a dramatic effect on patient well being. Further, with the severe shortage of adequately trained care givers, the humane side of health care is often neglected. We find human dignity often sacrificed just to get the job done.

Similarly, coordination of services both within and outside the rural hospitals is lacking. Over-all supervision and coordination of day-to-day patient care is jeopardized by the severe shortage of registered nurses and allied health workers, e.g., a 50-bed nursing home in rural Utah has one registered nurse on staff who is on call 16 hours a day, five days a week and is relieved by a hospital registered nurse the other two days. Coordinated care suffers when critical elements of services are not available.

Increasing the allied health workforce in rural America is facing many barriers. Students who leave the rural community for allied health training seldom return to the rural setting after experiencing better equipped centers and the cultural advantages of larger cities.

Non-traditional students (re-entry women and mothers whose children are grown, who may be available for training) often find it difficult to negotiate the barriers of entering the higher education systems of the nation.

Further, the lack of reimbursement for many allied health practitioners is a deterrent from working in rural areas, which are not seen as professionally or as monetarily attractive as urban centers. In contrast to their urban colleagues, rural health care workers find salaries lower, hours longer, limited opportunities for advancement, and outdated and/or unsophisticated facilities and equipment. Isolation from colleagues, along with limited cultural activities and opportunities for family members--all impede recruitment and retention of qualified practitioners.

In addition, some allied health fields have been slow to introduce a gerontological focus in their curricula. As most allied health curricula are overcrowded, introduction of new material is difficult. Thus, most allied health programs gear their content to accreditation essentials and, while some modifications in essentials are now being made, these processes are typically slow to change.

CALL FOR ACTION

The uncertainty over future employer and student demand makes any serious planning effort extremely difficult. Planning, in effect, is occuring in a vacuum. Currently, an imbalance exists in the supply-demand situation for the professions as a whole--with demand exceeding both actual supply and the applicant pool. The state of flux in health service delivery has created an entirely new scenario. Addressing these shortages and systematically tracking factors affecting growth rates of the professions must be priorities for the Federal Government.

There is a critical need for activities that reinforce the value of innovations in geriatric care education in allied health, particularly activities capable of bridging accreditation processes, through concensus building on the importance of geriatric care education.

The Society's National Task Force on Gerontology and Geriatric Care Education in Allied Health* is an example of just such an activity. The work of the Task Force required the expertise of a wide range of disciplines and the American Society of Allied Health Professions is pleased to have been able to enlist outstanding experts from diverse health backgrounds to consider these issues of the national import.

The Task Force explored both major trends that are occuring in our aging society and the implications of those trends for health care needs of older people. The report states that consideration must be given to following environmental elements:

1. Health care finance and policy changes already underway are reshaping allied health practice, increasing daily the importance of home and community based care.
2. Emphasis continues to grow on treatment and rehabilitation of chronic diseases and disabilities, maintenance of independent lifestyles, and health promotion and prevention methodologies, all areas falling more directly within the practice domain of the allied health professions.
3. Many allied health personnel do not have sufficient clinical training to care for the elderly in alternative care settings, such as nursing homes and home care, particularly in rural areas.
4. In-home assessment is becoming a normative expectation of allied health providers.
5. Assessment is needed of current and projected incentives which effectively encourage student, faculty, and clinician entry into needed areas.
6. Typical health problems of older people are multifaceted and require interactive and interdisciplinary approaches.
7. Additional data on practice and quality assurance are crucial to informed policy development and educational planning, as are the development of successful models of care.

THE FEDERAL ROLE
RECOMMENDATIONS

To address the practice issues for the allied health professions, intervention is required. Specifically, federal support and funding for allied health education via both the schools and professional associations of allied health are necessary to ensure sufficient care providers to meet the growing demands of our rural elderly.

Support is needed to address such issues as:

1. Revision of allied health educational programs and school accreditation standards to guarantee the inclusion of substantive geriatric and gerontological content and essential clinical experience in basic entry-level education.
2. Promotion of research activities by academic institutions and professional associations to:
    (a) document allied health personnel requirements (numbers and types) across diverse health care settings, particularly settings relevant to the aging in rural communities;

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*The 17 members of the Task Force, composed of nationally recognized experts in Gerontology and Geriatric Care Education, were nominated by their respective professional associations: The American Association for Physician Assistants, American Dietetic Association, American Dental Hygienists Association, American Nurses Association, American Occupational Therapy Association, American Association of Colleges of Pharmacy, American Physical Therapy Association, American Society for Respiratory Care, American Speech-Language-Hearing Association, and The National Association for Social Workers.

   (b) document quality, efficacy, and cost effectiveness of allied health services, using accepted outcome and process measures; and

   (c) Structure and evaluate new and effective treatments, methods, and therapies for use by allied health practitioners.

3. Cooperative programs between schools of allied health, rural hospitals, nursing homes, and National Health Service Programs for:

   (a) Onsite continuing education programs for rural health care workers;

   (b) Onsite rural teacher training programs for allied health practitioners to enable them to function as faculty for rural health worker preparation;

   (c) Interdisciplinary training of nursing and allied health practitioners in rural health care settings; and

   (d) Exchange of personnel and equipment between health care delivery sites.

4. Incentives to colleges and universities for increased flexibility in student recruitment, admissions, and educational programs for the preparation of rural health workers.

5. Incentives to encourage student, faculty, and clinician entry into the allied health professions to serve rural elderly.

6. Development of strong advocacy networks to inform national, state, and local policymakers about appropriate changes in the areas of reimbursement, long-term care insurance coverages, licensure, and health personnel training.

7. Expand the National Health Service Corps to include the allied health professions.

8. Creation of wider opportunities for allied health educational centers to compete for federally-sponsored training and research programs in geriatrics and gerontology.

9. Development of consumer education programs regarding the services of allied health professions targetted for older Americans.

The American Society of Allied Health Professions applauds the Senate Special Committee on Aging for addressing the critical issues of the American rural aging population. Obviously, the health care problems of the rural elderly cannot be viewed in isolation. Critical concerns for providers and patients include not only preparing providers to give care, but also access to care, including both transportation and reimbursement practices. While other issues (e.g., economics, long-term care, housing, mental health, employment, and guardianship) are not addressed in this testimony, the American Society of Allied Health Professions recognizes their integral roles in the provision of health care to the elderly. The Society stands ready to support your efforts in addressing allied health personnel and education issues.

ASAHP
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Item 10

MONTANA MEDICAL ASSOCIATION

2021 Eleventh Avenue • Helena, Montana 59601-4890
Telephone (406)443-4000 or In-State 1-800-MMA-WATS (662-9287)
FAX (406)443-4042

August 18, 1988
Thursday

The Honorable John Melcher
United States Senate
Hart Senate Office Building, Room 730
Washington, DC 20510

Dear Senator Melcher:

The Montana Medical Association is currently deeply involved in the loss of physician services to the smaller communities of rural Montana. We are particularly concerned with the loss of obstetrical services. Doctors are leaving the practice of obstetrics in rural communities and hospitals because of the escalating malpractice premium crisis. As a consequence, the Montana Medical Association has prepared legislation to deal with this problem to be presented to the 1989 session of the Montana legislature. Our proposal, if enacted, would a) immediately lower liability insurance premiums for doctors who deliver babies in Montana, b) immediately reverse the loss of obstetrical services in our state, particularly in rural areas, c) provide long-term relief in the form of controls on cost of litigation, in part by making payment for damages more predictable and, d) maintain the rights of injured parties to fair access to the judicial system.

The Montana Medical Association is concerned by the looming crisis caused by the progressive shortage of nursing personnel. The Montana Medical Association favors entry into nursing at any and all levels. Thus, we support maintaining the one-year LPN programs, the two-year associate degree programs, the three-year diploma programs and the four-year baccalaureate programs as well as graduate programs. We feel that we need nursing personnel at all of these levels in order that they may serve the patients appropriately whether trained to do so at the bedside or on a supervisory level. The Montana Medical Association is aware of the "Registered Care Technologists" approach proposed by the American Medical Association. At present we understand this is a pilot study being tested in two or three eastern states where there is a critical shortage particularly in urban hospitals. When this study is complete, we feel that Montana should keep its options open as to whether the two, nine or eighteen month trainees under the Registered Care Technologists program might be applicable to our state. We feel it is too early to endorse or reject this program until it is properly field tested.

Senator John Melcher
August 18, 1988
Page 2

Many of our rural patients are senior citizens covered under Medicare. Access to medical care must be maintained no matter whether a patient, a senior citizen, has the ability to pay. The Montana Medical Association favors a system whereby voluntary assignment may be granted to patients who are truly in need. Unfortunately, it is difficult for doctors in their offices to make decisions as to whether patients are truly needy. Therefore, the Montana Medical Association is embarking upon a program whereby truly needy patients can be identified and issued a card so stating. The vast majority of physicians in Montana would then honor this card and grant assignment for Medicare services to such patients. We hope to enlist the support of the senior citizen's groups in this program. We feel that such a program will go a long way toward maintaining access to medical care of our truly needy senior citizens. This would be much preferable to a legislated "mandatory assignment" program in that under such a system many doctors might be forced to opt out of seeing Medicare patients and thus, there would be a loss of access to medical care across the board.

In summary, the major concerns of the Montana Medical Association in 1988 are a) the loss of obstetrical liability services in rural areas, b) dealing appropriately with the shortage of nursing personnel in the state including rural areas and, c) maintaining access to care for senior citizens. We have proposed at least partial solutions to each of these critical problems. Thank you for allowing the Montana Medical Association to provide testimony before your exceedingly important Special Committee.

Sincerely,

F John Allaire M.D.

F. John Allaire, M.D.
President

#15262

FJA:ce

Item 11

TESTIMONY PRESENTED TO

Senator John Melcher, Chairman
Senate Special Committee on Aging
for July 11, 1988 Hearing

"THE RURAL HEALTH CARE CHALLENGE:
PART II: RURAL HEALTH CARE PERSONNEL"

Submitted by:
Anna M. Shannon, R.N., D.N.S., F.A.A.N.
Dean, College of Nursing
Montana State University
Bozeman, MT 59717

TESTIMONY

I am Anna M. Shannon, Dean of The College of Nursing at Montana State University, Bozeman, Montana. Our College is the largest provider of health care personnel in Montana. We have annually graduated an average of 150 baccalaureate prepared nurses and 4-5 master's prepared nurses in recent years. Montana's current economy has produced budget cuts that have now reduced our capacity to 120 graduates a year. We strive to prepare nurses to function in a rural state. Seventy percent of our baccalaureate graduates are employed in nursing in Montana upon graduation. Virtually all of our master's program graduates remain in Montana. Both programs focus on the health care needs of a rural state and the interaction between the cities and the sparsely populated areas in health care delivery. Our programs are fully accredited and our graduates are sought by employers in other states as well as in Montana.

During the last ten years the faculty members of the College, through the master's program in rural nursing, have collected and analyzed research data related to delivery of care in a sparsely populated state. Some of the concepts derived from this descriptive research help to explain the difficulty experienced in recruiting and retaining health personnel in rural communities. This testimony is offered in order to share these insights derived from our research.

The explanatory concepts that seem most relevant are: insider/outsider, newcomer/oldtimer, women's role, informal caregiver.

The impact of these concepts on the problem of recruitment and retention will be briefly discussed.

Insider/outsider, newcomer/oldtimer: This set of concepts show up in the data not only in regard to nurses but also for doctors. New nurses are not made a part of the community or sought out for neighborly nursing advice unless they are seen as oldtime, permanent, community members. Similarly, new doctors are seen for emergency care but not for long term association. National Health Service Corps doctors are seen as transients who do not emotionally invest in the community and in whom the community does not emotionally invest.

Representative segments from the research interviewing data follow:
(documentation of data source is given in parenthesis)

- Oldtimer status is gained as one is accepted by the rural community.
- Gypo loggers in ______________ reported specific classification systems for the oldtimer - newcomer-outsider distinctions for both residents and physicians. (Scharff, N511, 1982.)
- Community residents reported classification systems for oldtimer - outsider distinctions. (Peterson, N511, 1982.)
- Informal nurse caregiver in __________ area is not utilized by many community residents because she is a "newcomer". (Peterson, N511, 1982.)
- Newcomer RNs were viewed by other rural nurses with suspicion and were regarded as not understanding. (Bunde, N590, 1981.)
- Transient populations are perceived by "oldtimers" as disruptive to communities. They are blamed for the trend away from support of local services. (Snyder, N511, 1978.)
- Residents of this community are very loyal to it and many distrust "outsiders" regardless of their intent. (Smith, K. N511, 1980.)
- Residents prefer going to the closest urban center to establish a long-term relationship with a physician when they believe the local physician will not stay. Priority is for the long-term relationship and distance is not a problem. While people would like to have a local physician, they do not want to pay extra taxes or go to a local physician who might not remain in the community. (Wickham, and Goddard, N514, 1979.)

Women's role, informal caregiver: In the small towns of the rural area, women are identified in terms of their relationships to men, i.e., is the wife of, daughter of, sister of. Nurses, as women, (most nurses, 95%, are women) are similarly identified in relationship to men, rather than in terms of their professional role, nurse. Therefore, there is the expectation that they will volunteer their services, (be an informal caregiver) as other neighbor women do, so they are called on to provide much professional service without compensation. Additionally, new nurses may be employed part-time without benefits and/or be expected to take vacation days or days without pay on hospital low-census days. Despite their actual status as professional persons, nurses (as women) are not viewed as major wage-earners or heads of house-holds.

Representative segments from the research interview data follow:

- Clearly most women were viewed as someone's spouse rather than as persons in their own right. (Bunde, N590, 1981.)
- Nurses are related to as their husband's wives rather than in their own right. (Bunde, N590, 1981.)
- The rural nurse is always on call. (Bunde, N590, 1981.)
- The postmistress in ____________ is an RN, an EMT, teaches basic first aid to grade school children, teaches CPR and Advanced First Aid to community residents. She and one other resident act as the response unit (911 calls referred from Missoula.) when they are available. (Snyder, N511, 1978.)
- A rancher's wife, RN, is asked to do BP screening in clinics and in her home for community residents. (Balthaser, N511, 1982.)
- The two informal care givers in the __________ area most frequently named were both nurses and rancher's wives. (Balthaser, N511, 1982.)
- Part-time nurse in __________ Hospital is asked by hospital physicians to visit and treat discharged patients who live near her (without compensation).

  Members of the community call her (informally) to respond to train, car, airplane accidents. (Balthaser, N511, 1982.)
- The registered nurses in the community of ________ are called upon by community residents for advice as to whether or not a health need should be seen by an MD, for first aid, and for general health advice. (Veign, N511, 1980.
- There seems to be a hidden rule that if you are an RN you will be consulted and you should provide services to the community. Health care services here are provided by the goodwill and help from the nurses and your neighbors. (Veign, N511, 1980.)
- Nurses in ____________ are frequently consulted by area residents for health related concerns. This is both expected and accepted as a part of life in a rural community. (Peterson, NM539, 1983.)
- Two resident nurses in _________, who comprise the quick response unit, are called by the police to assist with accident calls outside of the area, are called by teachers to administer first aid, are called by gas station attendants to receive counsel and advice before contacting a physician. (Wicks, N511, 1980.)
- In _________, a retired RN is asked by community members for assistance with minor injuries and symptom validation. (Peterson, N511, 1982.)
- Resident nurses (2) in ____________ act as a Quick Response unit, and use their own money for splints, bandages, gas. (Wicks, N511, 1980.)
- Community residents of _____________ rely on three retired nurses for medical advice when the physician is out of town. (Mattocks, N511, 1980.)

Putting these concepts together then, we have a situation in which the new (often single) nursing graduate who is recruited to a rural hospital finds herself in a small town where she has no identity, where she is not integrated into the social fabric of the community (doesn't fit the normative role) and where she is expected to accept less income than the originally offered low pay. This new nurse usually has educational loans to repay, a desire for a pleasant standard of living, and cannot afford to subsidize rural health care delivery. The new physician, on the other hand, has his livelihood subsidized by the county (a guaranteed income of $80,000 is not unusual as a part of the recruitment package for a new physician). Additionally, townspeople do not freely drop in on the doctor at home to have their blood pressure checked or a splinter removed, nor is the doctor expected to run people into the hospital in his own car or join the highway patrol at routine accident scenes.

Subsidization of the salaries of nurses at a level commensurate with their preparation and importance, and staffing at a sufficient rate to allow the nurse to maintain her currency through continuing education, could be positive actions to solve the nurse shortage problem in rural areas.

Another partial solution to the problem would be for the rural hospital/community to provide financial support for local students interested in nursing, or local nurses interested in upgrading their education, to attend established, accredited, high quality nursing education programs. This support could have a 1 year to 1 year (1:1) payback to the hospital. This approach would assure that the quality of the education was maintained for the nurse who plans to practice in a rural setting and yet also assure that the rural hospital would have a future staff.

Expectations by some rural hospital administrators, that nursing education could be offered on an "earn while you learn" basis through their institutions, ignore the educational quality issues of diversity and complexity of clinical learning opportunities, adequate library resources, recruitment of well prepared nursing faculty and observance of standards to maintain accreditation. A professional nursing education program must prepare the nurse to be able to practice in New York City as well as Two Dot, Montana, not simply to be job-ready for a given institution in a specific rural town.

A plan such as that given above, namely scholarships with payback, would require the sending agency (hospital) to have either a position for that newly prepared nurse upon graduation or a plan for debt forgiveness.

A larger question needs to be addressed when considering rural hospitals. That question is: Can the staff of a very small hospital (e.g., <30 beds) have the diversity of nursing talent, and the opportunity to maintain clinical skills, sufficient to hold open an acute care hospital?

Segments from the research data illustrate this problem:

- Rural staff nurses need skills and competence in a variety of specialties: Nurses who are competent have problems maintaining skills due to lack of patient contact over time. (Kelly, N539, 1982.)
- Competencies are volume sensitive - the greater the number of cases, the higher the level of competency to provide skilled care. (Peterson, N539, 1983.)

Is the maintenance of these small institutions as acute care facilities providing these communities with a false sense of security? Would the needs of the citizenry be better served by establishing rural clinics with holding beds, associated with an extended care facility or nursing home, and staffed by nurse practitioners or nurse specialists? Such a facility could focus on patient stabilization, transport to a larger facility, and receipt of the patient back after care in the larger facility. Health care personnel in this circumstance would not be expected to maintain clinical currency in all specialty areas (as they are now) and patients could receive help from persons who care for the condition frequently--both physicians and nurses.

Counties are reluctant to give up "their hospital" because of this (false) sense of security and because it is often the largest industry in the county. The cost of maintaining an acute care facility needs study to see if alternatives might not be both clinically superior and more cost effective.

Certainly a redefinition of the very small rural hospital into a rural clinic would have an impact on the nursing shortage in these institutions.

Summary: This testimony has presented research data that suggest that a fundamental change needs to go into rural hospital configurations and nursing staffing if the nursing shortage is to be addressed by any long-term solutions.

8/88 AMS Irma M. Shannon

Item 12

Statement

of

Alan Strange, Ph.D.
Chairman
Rural Task Force

on behalf of the

National Association of Community Health Centers, Inc.

to the

Senate Special Committee on Aging

on

RURAL HEALTH CARE PERSONNEL

Mr. Chairman and Members of
the Committee

My name is Dr. Alan Strange. I am from Billings, Montana, and I currently serve as Chairman of the Rural Task Force of the National Association of Community Health Centers. The National Association of Community Health Centers represents over 600 Community and Migrant Health Centers throughout our nation including 355 rural Community Health Centers and nearly 100 Migrant Health centers located in rural areas. Combined, these primary care facilities provide basic health care to over 6 million low-income and disadvantaged patients each year.

I. INTRODUCTION

The Rural Task Force of the National Association of Community Health Centers is pleased to provide information concerning the role of Community and Migrant Health Centers and other private/public efforts in the delivery of health care in rural communities.

The rural areas of the United States have long experienced shortages of all levels of health care. It is apparent that, using the twin criteria of access to care and affordability of care, the plight of rural Americans has deteriorated even further in recent years. While all rural residents are affected by current shortages and the rural economic downturn, those groups most threatened by the deterioration of the rural health care system are the elderly, infants and children, and high risk pregnant women. Those groups generally need access to more frequent care, greater variety of health services, and frequently, more intensive services. They are generally less able to withstand rapidly increasing costs and are most quickly placed at risk by forces which tend to decrease availability of health services or raise the cost of those services. The recent rural experience has been a services decrease in access to the health care system, coupled with a sharp increase in the cost to the rural individual of obtaining care at all levels.

Access

The American health care system is often said to be the finest in the world. Providers and caregivers within our system are trained with, and supported by, the finest technology money can buy. While the system has some acknowledged faults, including the requirement that providers often must make difficult choices regarding who does, and who does not, gain access to the highest technological levels of care, in general the medical advances which lead to those difficult choices have provided enhanced ability to protect life and health across the broad spectrum of disease and illness entities. The success of the health care system, however, especially one of such complexity, requires established communication systems among providers, the ability to organize numbers of services for any given patient, often rapid movement to more sophisticated levels of care, and the management of services provided to the patient. This management is important, both to assure that the individual receives necessary services, and to avoid duplication of, or unnecessary provision of, expensive care. It should assure, to the best of our ability, that the individual receives quality care at the least expensive level consistent with effective treatment, and that the individual has access to increasingly sophisticated care as necessary. That is a difficult thing to consistently do correctly, and our system is programmed to err on the side of higher level, more complex services. The training we receive and the liability we assume for the health and lives of our patients argue always for more comprehensive, and therefore more expensive, interventions, under considerable pressure. We call such services case management, a term of great recent popularity, which unfortunately focuses on the patient rather than the services provided to the patient. The focus of governmental policy of all levels should be the assurance of access to affordable care through effective utilization of the spectrum of care. Public policy cannot manage 230 million Americans one by one. Governmental policy can, and does, affect the way the health care system approaches its clients. In too many areas, that policy encourages restrictive access, system breakdown and overspending.

As examples:

- The attempt to restrict payment to hospitals through Medicare prospective payment, by 1986 had resulted in payments to one out of every ten rural hospitals of one-third *less* than their costs of providing care for covered Medicare patients. The rate of closure of community hospitals has, since 1986, been staggering. Those small, rural hospitals form a necessary link in the present health care continuum, breakage of which denies access for those patients to services on either side of that link.

- Our physician training system emphasizes large teaching hospitals with rapid access to extensive technology and highly trained specialists. Such training does not prepare a practitioner for the less sophisticated practice setting found in most rural areas. Discomfort with practicing in a setting for which the individual has not been trained, coupled with anxiety producing liability expectations, cause fewer medical graduates to choose rural practice sites. As the hospital closure trend accelerates, this problem will be exacerbated.

- Lack of a viable response to the liability insurance crisis has caused shortages of obstetrical care in rural areas due to negative cost/volume figures for providers who perform relatively few deliveries. In many cases those family practitioners were the access point through which high risk mothers and infants were referred into the spectrum of care. Without such access points, the chance for negative outcomes in risk pregnancies increases.

In general, our emphasis on very sophisticated technology and very expensive comprehensive training, coupled with the trend toward the presentation of providers as infallible miracle workers who can err in treatment only at the cost of expensive monetary judgments, has left us with a care system so complex, so technically comprehensive, so expensive to operate, that it depends for its viability on volumes of patients not generally found in rural areas. The dollars spent on this system, predicted to reach *$1.5 trillion* by the year 2000 are said by many to preclude additional expenditure for any reason. In such a situation, millions of rural Americans will be left with no access, or differentially low access, to the spectrum of care. And severe access problems exist. Shortages of physicians, nurses, pharmacists and hospital facilities continue to plague rural America, while the economic crisis threatens to worsen, rather than alleviate those shortages. Many rural communities have no access point from which to enter the care system. Almost 1,300 rural geographic physician shortage areas are currently identified by the Department of Health and Human Services, requiring a much greater number of physicians to provide adequate entry level care for those populations. Rural counties have less than half the physicians per 100,000 population as urban counties. The smallest rural population areas have less than one-sixth the number of physicians per 100,000 as urban areas.

Other rural areas often have to choose between equally necessary services. They may have a physician, but be unable to afford home care, emergency medical services, mental health, or other necessary elements of the care spectrum. While it is not cost effective to provide all levels of care next door to every American, it is necessary to assure that every citizen has an access point through which those other levels may be obtained as necessary.

Affordability

High technology health care operates on the availability of expensive care spread across a high volume of patients to make such care affordable for each individual patient. Rural residents are likely to pay more for care than their urban counterparts because the cost of assuring availability of that care is spread over fewer patients. Rural residents experience lower rates of coverage by both public and private programs. All rural residents, as a group, have a 15 percent higher rate of uninsuredness than the U.S. average, and a 24 percent higher rate than their metropolitan counterparts. In general, rural families have less financial ability to purchase care. With 25 percent of the nation's population, rural America has 38 percent of the nation's poor. Of the 86 counties nationwide in which one-third or more of the residents live in poverty, all but one are non-metropolitan. With respect to public funding of health care, rural areas consistently lag behind the national average. Federal per capita expenditures for health services are 42 percent lower for rural residents than the U.S. average. More than 70 percent of the rural poor live in states where the maximum AFDC benefits are below the national median. The rate of qualification for public assistance is 37 percent lower in rural areas. More than 75 percent of rural residents below the federal poverty level do not qualify for public assistance.

The economic crisis in rural America has exacerbated the problem of affordability. Rural residents pay, on average, 10 percent more of their income out of pocket for health care than do their metropolitan counterparts. Inflation continues to threaten the ability of those on fixed incomes to continue to access increasingly expensive care. As stated earlier, the situation is worse for those groups who need a greater variety of health services, at more frequent intervals, and often at higher levels of specialization. This group includes many of the rural elderly. One of every five elderly non-metro residents lives in poverty, a rate 15 percent higher than for elderly residents of the U.S. as a whole.

The Committee has heard testimony regarding the current plight of hospitals. That problem is well documented and rural America cannot afford to lose access to that portion of the health care spectrum. Of equal importance, however, is the fact that many rural residents have no access point from which to enter the spectrum and obtain hospital care.

The National Association of Community Health Centers believes that governmental policy concerning primary care should have three objectives:

1. Development and support of access points which provide primary care to all patients; which assures the patient's ability to obtain related care as necessary, including outreach, mental health services, home care and emergency services; and which, in a coordinated manner, act to facilitate patient entry to, and return from, more specialized care such as surgery or long-term care.

2. Financing to sustain those access points and to assure that they are open to all potential patients, as viable points of entry to the health care spectrum.

3. Manpower sufficient to meet the goal of provision of cost effective, quality care to all rural Americans.

To obtain those three objectives, in some cases existing federal policy should be enhanced. In others it may require change. In some cases, as discussed below, policies already in place affect more than one proposed objective. All federal policies, developmental, financing, and education/training, should be examined to determine whether they encourage or discourage adequate distribution of providers and access points.

II. ACCESS POINTS

Federal policy affects the development and existence of several types of access points needed by rural residents. These include Community and Migrant Health Centers, free standing National Health Service Corps sites and Certified Rural Health Clinics. It also, through encouragement and reimbursement, will affect the ability of rural hospitals to become less comprehensive ambulatory care centers, as with the new Medical Assistance Facility legislation provided under Montana state law. All the above programs have the capability to increase rural access points and, to a greater or lesser extent, strengthen the spectrum of rural care. As such they deserve the consideration of policymakers as options of choice.

Community and Migrant Health Centers (C/MHCs)

There are approximately 355 Community Health Centers and nearly 100 Migrant Health Centers now in operation in rural areas, serving residents of medically underserved (MUA) or health manpower shortage areas (HMSAs), under Section 330 and 329 of the Public Health Service Act. In view of the access and affordability problems presented above, these centers have several advantages as care providers, including:

- Federal funds to serve those poor and near poor patients who are nevertheless above state Medicaid income eligibility cutoffs.

- A mandate to serve Medicare/Medicaid patients for the set reimbursement only, with no further cost to patients below the federal poverty level and with decreasing amounts of assistance for those earning up to twice the poverty level.

- The ability to provide a wide range of mandated and permitted basic health services, including medical, dental, lab, x-ray, pharmacy, mental health, outreach, health education, emergency care, and formal linkages with specialty and hospital care providers. This is a distinct advantage in isolated areas where such allied services are scarce or nonexistent, as well as an excellent way to manage services provided to a patient across the care spectrum in a cost efficient manner.

Community Health Centers are a part of the "safety net", assuring services to all residents, especially needed in areas where Medicaid falls short of its intended function. As documented time and again, they provide services at a very low cost per user compared with other models.

That being the case, it is disappointing to note that there has been service erosion over the past few years in the ability of this program to meet the need for services in rural areas. Funding has been frozen for the past three years, and between 1986 and 1987, the number of rural Community Health Centers declined from 390 to 355, a decrease of 9 percent. As funding has remained constant and costs of care have increased, both the absolute number of centers, and their ability to provide the range of necessary services discussed above, have decreased. At the same time, the economic crisis has placed more demand on the ability of centers to care for the poor. A recent study shows sharp increases in the number of families applying for discounted services. Accounts receivable and bad debt threaten the ability of the centers to operate under current funding. Existing centers are in need of increased funding to continue established levels of care without expansion. Given the fact that only 355 such centers exist, with only 17 in the very isolated frontier areas, little chance exists for expansion of Community Health Center services within the nearly 1300 shortage areas designated by the Department of Health and Human Services. Indeed, we are likely to see reductions in both availability of basic services and variety of services provided without substantial funding increases.

Certified Rural Health Clinics (RHCs)

In access points, Certified Rural Health Clinics share some of the advantages of Community Health Centers. This is a reimbursement category for Medicare and Medicaid, not a grant program. As such, it does not provide funds for care of the poor and near poor who do not qualify for Medicaid. Certified Rural Health Clinic status does however:

- Mandate use of midlevels, providing a cost effective means of providing basic primary care;
- Stabilize revenue for Medicare and Medicaid visits on a *cost based*, all-inclusive rate;
- Permit primary care to be delivered at home, or where-ever the patient is, and provides reimbursement for home health services in shortage areas. This is an advantage where variety of services is less than comprehensive.

The Congress has recently raised the cost cap on reimbursement of covered services to a more realistic level. There are, at present, some 400 Certified Rural Health Clinics nationwide, a consequence of long inadequate levels of reimbursement. The National Association of Community Health Centers has initiated a technical assistance effort to increase the number of Certified Rural Health Clinics. We hope that the Congress will continue to encourage the expansion of the certification effort, as the legal clinic status is an excellent way to attack access problems of Medicare- and Medicaid-eligible rural residents.

National Health Service Corps (NHSC)

As previously indicated, much of health and medical care in the private sector is a high expense, volume dependent business. The NHSC is a program which directly affects access by directing distribution of providers. NHSC physicians are, because of their obligations of loan or scholarship repayment, often the only providers available in shortage areas. At present, obligated providers may discharge their obligation by practicing privately in a designated shortage area; as a salaried member of a provider organization in such an area; or as a federal employee. Advantages of this program, in terms of access and affordability, include:

- Placement of health care professionals in areas not covered by fee for service providers because of low volume;
- The obligation of the provider to treat all presenting patients, regardless of ability to pay.

Financing of this program was drastically reduced several years ago, based on a projected physician glut which has never been felt by rural areas. Present loan repayment initiatives have been a help, but the program needs greatly increased funding to meet the continuing need for providers in rural shortage areas, as well as expansion of current policy to attract nurses and midlevel practitioners as a means of increasing the cost efficiency of care provision and ameliorating the nursing shortage. While this program is voluntary in nature, it may be time to at least discuss the response of many other industrialized nations to correct maldistribution of physicians. Given all of the public support for medical education, through direct tuition and costs support, research and training grants to educational institutions, and other substantial support, perhaps we should consider compulsory service in a shortage area for some period of time as a possible option. At the very least, we should require that education and training supported by public dollars assure field experience in shortage areas, especially for primary care disciplines.

III. FINANCING ACCESS

Since we have begun to discuss the financing of access through manpower training, and because access and affordability are interconnected, the experience of Community Health Center providers working in rural areas has provided us with recommendations for federal policymakers in the following areas:

- Granted that some areas will never approach the volume necessary to attract private sector providers, one policy decision which would be very helpful is a commitment to reimburse providers, including Community Health Centers, hospitals, and others, for the costs of services provided. The prospective payment system, and the urban/rural differential reimbursement rates currently in effect are capricious and damaging to the continued viability of rural providers.

- Rural people tend to have had lower paying careers then their urban counterparts. At retirement, this places them on lower fixed incomes. Medicare's coinsurance requirements, as presently in effect, are burdensome for this population, especially those caught between Medicaid eligibility and the federal poverty level. Medicare catastrophic legislation is excellent, but leaves a need for services not covered by Medicare, including preventive care and pharmacy. We need federal policy mandating full Medicaid service coverage for all poor and near poor elderly, to assure the variety and affordability of services needed by that group.

IV. MANPOWER

Much of the discussion of manpower is contained in other areas. We would ask, however, that discussion of policy initiatives or revisions address three additional concerns:

- Rural areas cannot afford a nursing shortage. This is partly because the lack of financial resources precludes successful competition for scarce personnel in most cases. More to the point, areas with scarce service resources tend to combine services within individuals. In rural areas, particularly isolated areas, traditional nursing care is only one of the jobs a nurse is requested to perform. They may be asked, without reimbursement, to validate illness of community members before expensive trips to more expensive providers are undertaken. They are expected to act as social service personnel, mental health counselors, health educators, outreach workers, and myriad other providers for residents of all ages. They have been, and are, effective, cost efficient front line providers, and incentives should be provided, along with rural field experience, through federally funded or sponsored education/training opportunities to assure that this cost-efficient provider resource will not be lost to rural residents.

- Recognizing that cost/volume forces operate to deny private practice physician coverage to areas of low population density, and act to lower the cost efficiency of federally funded physician care in those same areas, the utilization and training of midlevel practitioners should be a high priority, encouraged in the same manner as discussed under physician and nurse training programs. Midlevels are lower cost, high quality providers of choice for areas of low population density, and the expansion of Certified Rural Health Clinics depends on an adequate supply of such practitioners in the workforce.

- It seems reasonable to look at provider entities in the same way one looks at individuals. That is, in areas of scarce resources, providers with a broad range of service talents are more useful than specialists. In areas of low income and scarce financial resources, the lowest cost care which assures favorable outcomes is the care of choice. So we choose family practitioners over cardiologists, and encourage the use of midlevels. Similarly, we should place a high priority on the expansion of Certified Rural Health Clinics because of the variety of services they can provide. And we should place a *very* high priority on Community and Migrant Health Centers. Not only do they provide the greatest variety of needed services in rural areas, but they provide high quality primary care at a very low cost per user. Community and Migrant Health Centers are clearly the best delivery system to assure quality primary care to all rural Americans regardless of their financial status.

Mr. Chairman and members of the Committee, I deeply appreciate the opportunity to present this information to you today.

Item 13

NASW

National Association of Social Workers, Inc.
7981 Eastern Avenue
Silver Spring, Maryland 20910
(301) 565-0333

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July 19, 1988

Senator John Melcher, Chairman
Special Committee on Aging
SD-641 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Melcher:

I am pleased to submit to you the enclosed Preliminary Report of the Geographic Distribution of Mental Health Providers for the record of the Special Committee on Aging Rural Health Care Personnel hearing. The pilot study was done by the National Center for Social Policy and Practice.

The report shows a significant number of counties in the six states surveyed have no licensed psychologists, social workers, or psychiatrists: 101 counties in Texas, 13 counties in Illinois, one country in Michigan, 23 counties in Oklahoma, and 11 counties in Florida. Most of these counties are rural.

Social workers, according to the report, are often the only mental health providers available, particularly in rural areas. In all states but one (Florida), the percentage of counties with only social workers was at least 25.5 percent (Texas) and as high as 33.8 percent (Oklahoma).

These statistics show that large numbers of Americans, including the elderly, have limited access to mental health care providers. The maps in the report show that the situation is most critical in rural areas.

Some Federal policies serve as further barriers to obtaining needed mental health services. For example, Medicare does not directly reimburse social workers even though licensed by their states to practice as mental health professionals. For individuals living in counties served only by social workers, changing this policy is particularly critical.

NASW applauds the efforts of the Special Committee on Aging to investigate the availability of health/mental health services in rural areas. People of all ages can benefit from collecting this information and making policy recommendations aimed at improving access to health care.

Sincerely,

Mark Battle

Mark G. Battle, ACSW
Executive Director

MGB/jm

PRELIMINARY
REPORT OF THE GEOGRAPHIC DISTRIBUTION
OF MENTAL HEALTH PROVIDERS
(A PILOT STUDY)

Commissioned by the Department of Legislative Affairs
National Association of Social Workers

JULY 1988

REPORT OF THE GEOGRAPHIC DISTRIBUTION OF MENTAL HEALTH PROVIDERS

(Pilot Study)

Understanding a community's access to mental health care requires the enumeration of manpower available to provide these services. In addition, it requires a descriptive geographic distribution of the mental health care providers by type and level of training. Mental health service providers for purposes of this discussion are psychiatrists, psychologists and social workers, although it is recognized that other providers may also offer various services.

Knowledge about the issues surrounding the maldistribution of mental health professionals in this country is not uniformly apparent among the nation's legislators and policymakers. The extent of the shortages of certain providers in underserved communities is often lost in the national and statewide aggregated counts and projections of health manpower. As national and state legislation is developed, there is a danger that people residing in the less populated rural and poorer areas of this country will be unable to obtain access to mental health care providers because of de-facto exclusionary policies which deny direct reimbursement (Medicaid and Medicare) for social workers who are the principle providers of mental health services in many of those areas.

Policymakers, at the national and state levels, are presently considering or developing laws and regulations to improve access to mental health services, particularly at the community level. Financing alternatives and authorization of direct reimbursement for various providers under Medicare and Medicaid are being debated. Accordingly, it is imperative that policymakers recognize the important role of social workers in the delivery of mental health services to areas that otherwise would be underserved. In order to continue to make these services available, it is essential that social workers be included in the financing and reimbursement packages under consideration.

Studies of the future of the American health and mental health systems and the relationships among the mental health disciplines would be incomplete without consideration of the contribution made by nonpsychiatric providers. Many people who visit health care providers are without evidence of organic pathology but are suffering from psychological or maladjustment factors. Because of declining psychiatrist-to-population ratios, psychiatrists will tend to treat only the "sicker" patients and psychologists and social workers will assume more responsibilities for triage and treatment of other patients in need of mental health services.

Since there are approximately 300,000 social workers in this country and fewer than 30,000 psychiatrists and 45,000 licensed psychologists, it may be postulated that more social workers are serving the less populated rural and poorer areas of this country than the other two types of mental health providers. People residing in rural areas, particularly the poor, are more likely to use whichever mental health professional is geographically closer rather than a provider who is located at a great distance.

Knesper, et al (1984) found that, in 1980 there were strong relationships among the location patterns of the three types of mental health providers. The counties with high psychiatrists-to-population ratios were also likely to have high ratios of psychologists and social workers. One explanation for this phenomenon of similar distribution patterns for the three provider types was that they were attracted by the same environmental characteristics. Counties with higher incomes, higher educational attainment, more urbanization and with other health resources were more likely to attract all types of health providers.

In 1988, we face a new series of questions based on the health care system's movement toward a competitive model of delivery and the resulting changes in referral and reimbursement patterns. Specifically, the increased availability of direct public and private insurance reimbursements for psychologists and social workers, along with the declining numbers of psychiatrists (Jenkins and Turk, 1983), will change the distribution patterns of psychologists and social workers.

The National Center for Social Policy & Practice undertook a pilot project to test the feasibility of collecting information on the geographic distribution of psychiatrists, psychologists and social workers by county in six states. The states selected for this pilot project were: Michigan, Illinois, Oklahoma, Texas, Florida and West Virginia.

The purpose of this project was to test the feasibility of developing a county-by-county geographic distribution count (numerical and provider/population ratio) of psychiatrists, psychologists and social workers providing direct services in selected states. This information will demonstrate to national and state policymakers that in order to make mental health services geographically and financially accessible to the rural and disadvantaged populations of this country, direct reimbursement for the services of social workers needs to be authorized through all proposed mental health payment plans.

METHODOLOGY

Six states were selected on the basis of regional distribution, rural-urban mix, and varying licensure laws.

The latest available enumeration and distribution of psychiatrists by county was obtained from the Health Services and Resources Administration's Area Resource File. This was the 1983 data from the American Medical Association. The enumeration of psychiatrists counted board-eligible and board-certified specialists and treated each psychiatric resident as one-half of a psychiatrist equivalent.

For social workers and psychologists, actual 1988 lists of state licensed practitioners were solicited and received from the state licensing boards of the respective states. As anticipated, the diversity of state definitions and licensing law requirements for both psychologists and social workers necessitated state-by-state interpretation. Where multilevel licensing was utilized, only the higher levels were considered for inclusion. Specifically, psychologists were only considered with Ph.D. degrees except in West Virginia which licenses psychologists with a masters degree. Social workers were only counted if the level of license required a minimal attainment of the MSW. Florida has a restrictive licensing law and only social workers in private practice tend to be licensed. Those social workers in public agencies do not usually obtain licenses and therefore social workers are undercounted compared to actual MSW providers. For a true delineation of mental health providers, some states may require the use of other sources of data.

The U.S. Bureau of the Census' estimates of the 1986 population of counties was used to calculate the provider to population ratios for psychologists and social workers. The actual 1983 county populations were used to calculate the ratios of psychiatrists per population ratios.

The 1987 per capita incomes for the states and counties was based on estimates from the U.S. Bureau of the Census.

FINDINGS

In five of the six states studied to date, social workers outnumber the other two types of mental health providers. The provider per 100,000 population ratios for the states are presented in Table 1. The preponderance of social workers in all of the states is consistent with the exception of Florida.

TABLE 1
PROVIDER TYPE PER 100,000 STATE POPULATION

STATES	PSYCHIATRISTS	PSYCHOLOGISTS	SOCIAL WORKERS
Illinois	9.5	19.4	53.1
Michigan	10.1	14.7	92.0
Oklahoma	5.5	10.5	23.1
Texas	8.5	13.7	32.6
Florida	8.5	17.3	16.6*
W. Virginia	5.5	13.9**	43.6

* Florida license requirements are restrictive and required only for private practice.

** W. Virginia licenses masters and M.S. and Ph.D. psychologists

The number of counties in the selected states without any mental health providers (psychiatrist, psychologist, or social worker) was determined and the results are provided in Table 2 below. The data was then examined to determine which counties are without psychiatrists or psychologists, but are served by social workers. These counties are identified in blue on the state maps at the end of this report.

TABLE 2
UNDERSERVED COUNTIES IN SELECTED STATES

STATES	TOTAL COUNTIES	COUNTIES WITH NO PROVIDERS		COUNTIES SERVED ONLY BY SOCIAL WORKERS	
	No.	No.	%	No.	%
Illinois	102	13	12.7%	34	33.3%
Michigan	83	1	1.2%	23	28.0%
Oklahoma	77	23	29.9%	26	33.8%
Texas	254	101	39.8%	65	25.6%
Florida	67	11	16.4%	3	4.5%
W. Virginia	55	2	3.6%	14	25.5%

As Table 2 illustrates, licensed social workers represent the only category of mental health care providers in approximately one-fourth of the counties in the states studied. There is broad geographic diffusion of social workers and as expected, the counties served only by social workers are rural and have lower per capita incomes than the state as a whole. This is demonstrated in Table 3 where the counties served only by social workers have per capita incomes approximately 25 percent below the state-wide average per capita income.

TABLE 3

COUNTY PER CAPITA INCOME AND PROVIDER DISTRIBUTION

1987 (est.) MEDIAN PER-CAPITA INCOME

STATE	State Median	Counties Served Only By Social Workers			Percent Below State Median
		No.	%	Per cap.	
Illinois	$12,575	34	33.3%	$10,347	17.7%
Michigan	$10,584	23	28.0%	$7,872	25.6%
Oklahoma	$11,462	26	33.8%	$8,194	28.5%
Texas	$11,787	65	25.6%	$9,060	23.1%
Florida	$12,558	3	4.5%	$8,397	33.1%
W. Virginia	$8,434	14	25.5%	$6,686	20.7%

Table 4 is a summary of the distribution of providers which shows a clustering of the psychiatrists, psychologists and social workers in the majority of the counties. This geographic clustering occurs primarily in the urban counties, and the provider-per-population ratios for all three mental health providers are high. The study findings also demonstrated that the counties with no providers were usually contiguous with counties served only by social workers; this is visually shown on the colored maps on pages 12 to 17.

TABLE 4

PERCENT OF COUNTIES SERVED BY TYPES OF PROVIDERS

State	Psychiatrist, Psychologist & Social Worker	Psychologist & Social Worker Only	Social Worker Only	None	Other*
Illinois	29.4%	18.6%	33.3%	12.7%	5.9%
Michigan	42.7%	26.8%	28.0%	1.2%	1.2%
Oklahoma	18.2%	14.3%	33.8%	29.9%	3.8%
Texas	19.0%	10.2%	25.6%	39.8%	2.7%
Florida	52.2%	9.0%	4.5%	16.4%	17.9%
W.Virginia	36.7%	34.5%	25.5%	3.6%	5.5%

* Primarily psychiatrist and social worker

DATA LIMITATIONS

Measures of provider distribution depend on available information. Records of licensed providers are compiled by "place of residence" rather than actual employment site. The data does not allow a determination of active employment in the profession. Some of the licensed providers may be retired or otherwise not employed in the mental health field and their status is unable to be determined from license lists. This problem will be the same for all three provider types.

SUMMARY AND CONCLUSION

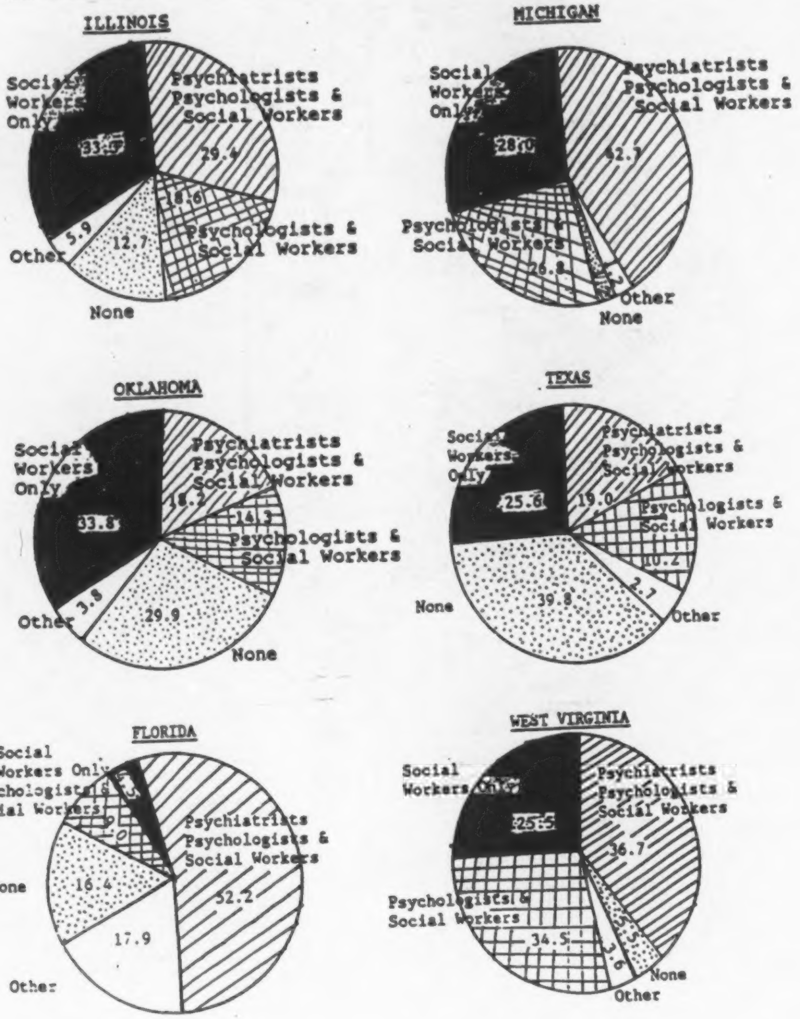
Mental disorders are common throughout the United States, in rural areas as well as in cities. Equal access to mental health services for people residing in rural counties necessitates the geographic presence of providers. Psychiatrists tend to set up practice in the larger urban areas where the educational and professional institutional affiliations are available. The psychologists and social worker per population ratios are also higher in the urban areas for similar reasons. Social workers are, however more geographically dispersed and more likely to reside in rural counties than other mental health providers. Therefore, they are the primary providers of mental health services in many of the rural and lesser affluent counties of this country.

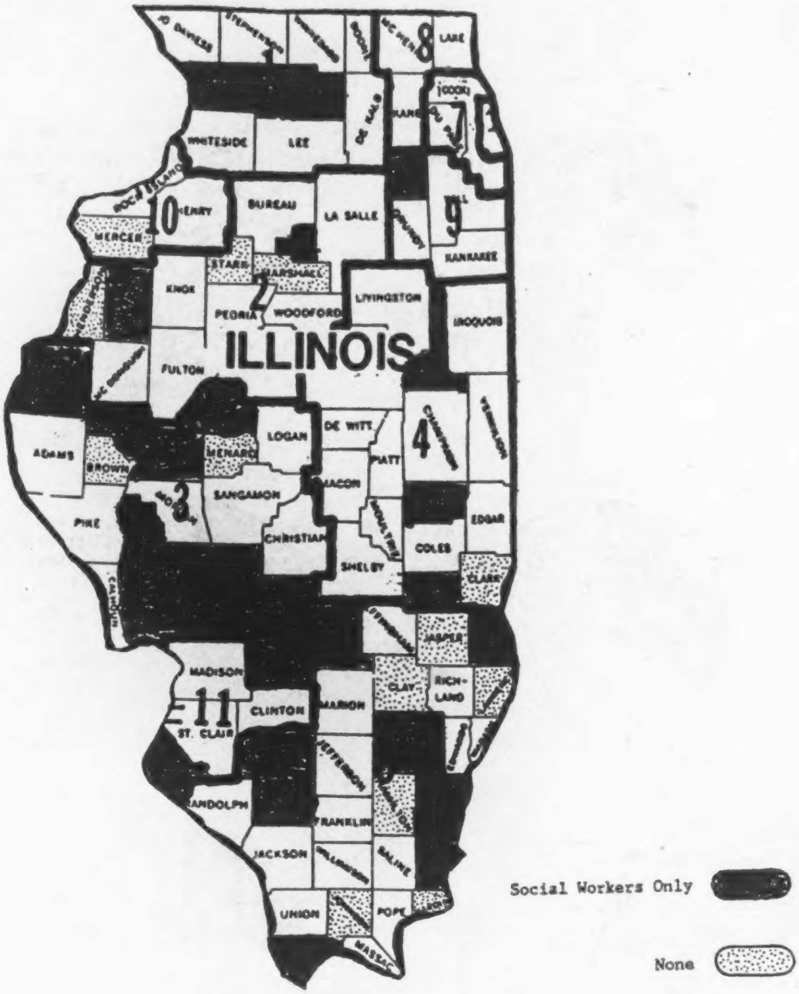
A future study should be undertaken to review the clinical tasks performed by social workers who reside in those rural counties and to define the scope of mental health services which they provide.

****

PERCENT OF COUNTIES SERVED BY

PROVIDER TYPE

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LEE
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BUREAU
LA SALLE
WILL
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MERCER
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KNOX
PEORIA
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LIVINGSTON
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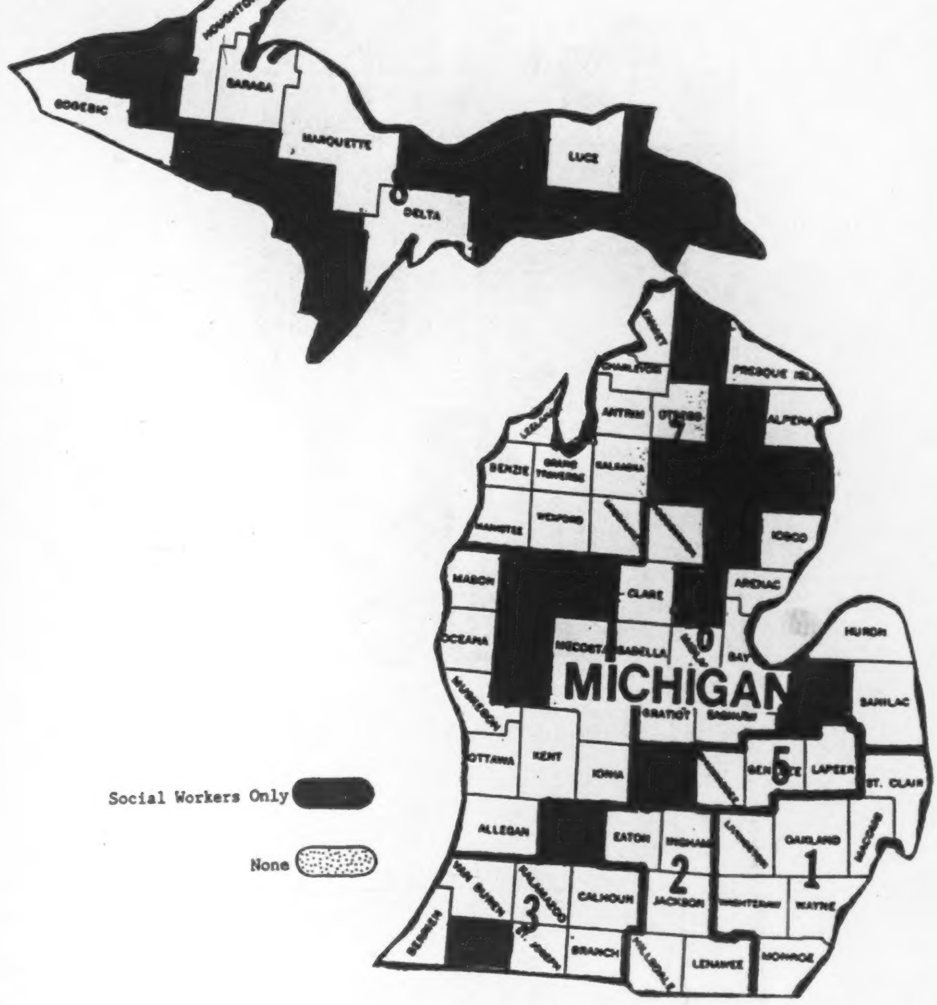
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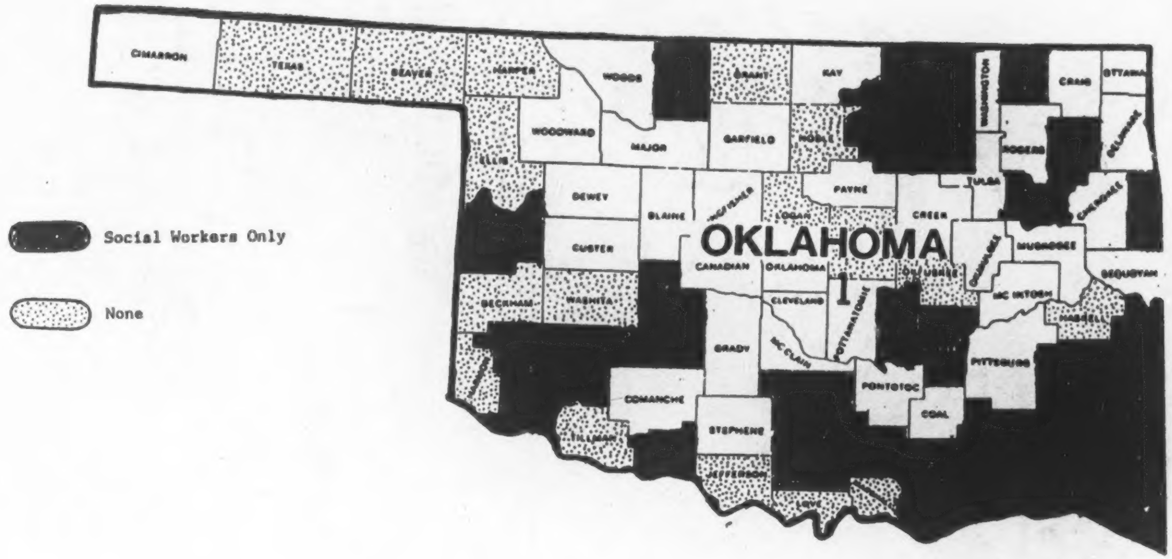
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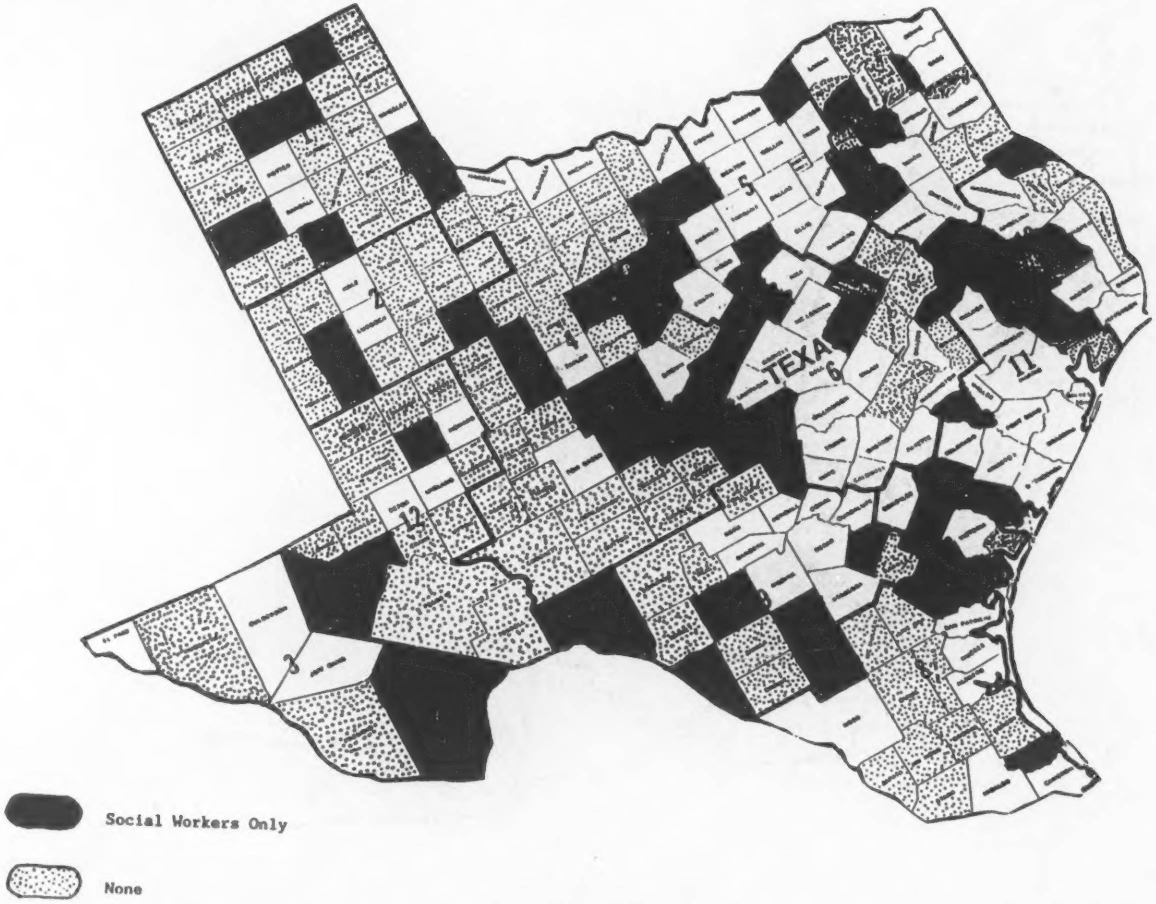
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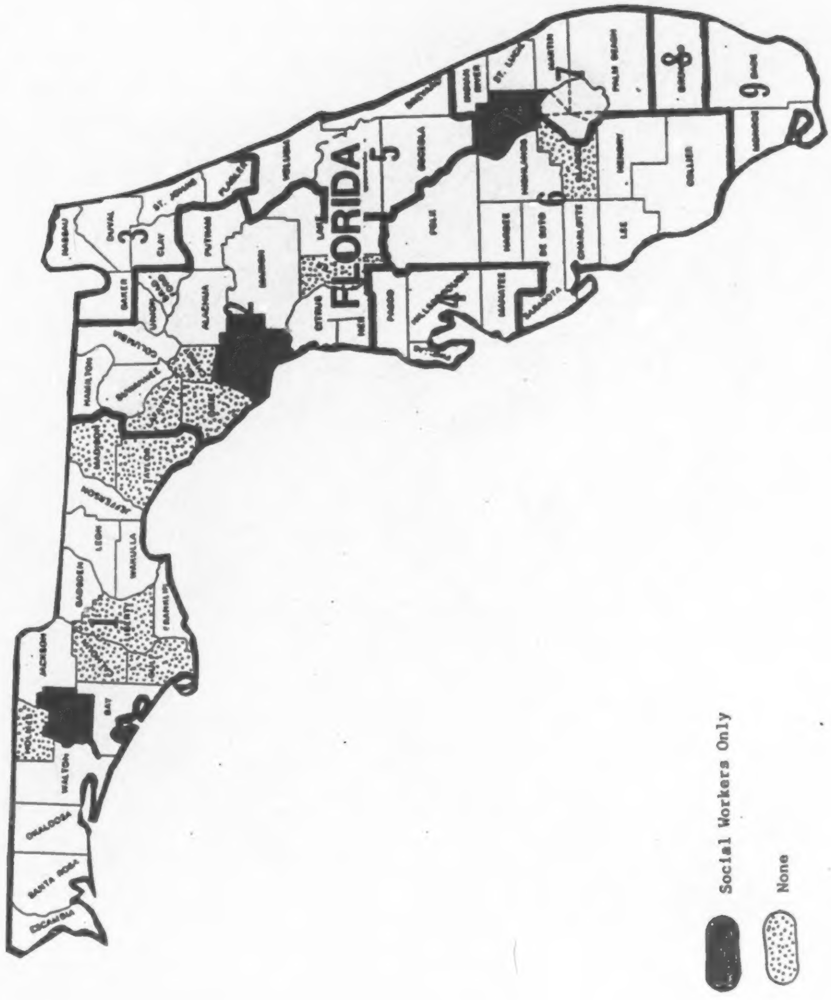
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Social Workers Only
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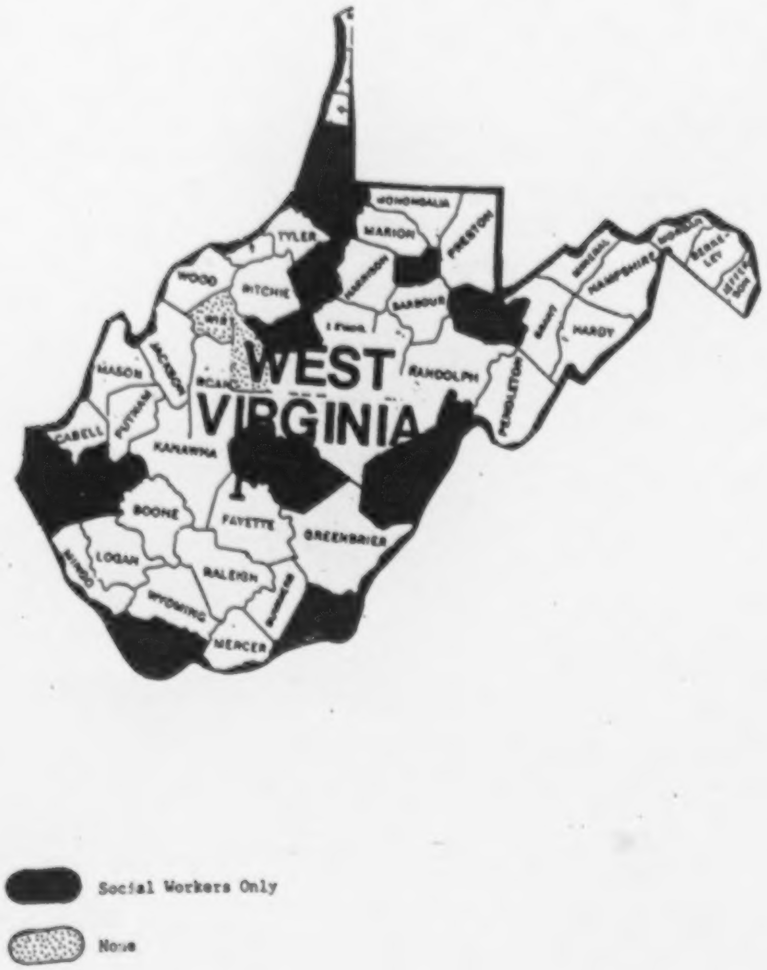
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Social Workers Only
None

Item 14

WEBER STATE COLLEGE

DEAN, SCHOOL OF
ALLIED HEALTH SCIENCES

OGDEN, UTAH 84408-3901
801-626-7117

MEMORANDUM

TO: Senator John Melcher, Chairman
Special Committee on Aging

FROM: Reed M. Stringham, Dean
School of Allied Health Sciences
Weber State College
Ogden, Utah

DATE: July 12, 1988

SUBJECT: Issues/concerns Senate Committee on Aging/Rural Health

ISSUES

- The quality and variety of services provided to the elderly in rural America are severely diminished by the lack of adequately trained health workers to provide these services.
  - In the past, nurses and LPNs in rural health care facilities provided many of the "allied health services" for patients with little or no training.
    e.g.: In one small rural hospital practical nurses were doing lab tests and in another taking some x-rays.

- Over-all supervision and coordination of day to day patient care is jeopardized by the severe shortage of R.N.s.
  e.g.: A 50-bed nursing home in rural Utah has one R.N. on staff who is on call 16 hours a day, five days a week and is relieved by a hospital R.N. the other two days. Obviously, coordinated nursing care suffers but the coordination of care by allied health workers is also jeopardized.

- Education/training for allied health workers for the rural health care system is inadequate for several reasons--among them are the following:

  - The exposure to clinical learning experiences is severely limited.
  - Adequately prepared and experienced teachers are for the most part not available to rural communities.
  - Students who leave the rural community for allied health training seldom return to the rural setting after experience in the better equipped centers and experience with the cultural advantages of larger cities.
  - Non-traditional students (re-entry women and mothers whose children have left but who have a farm or business in the rural community, etc.) are available for training

but often find it difficult to negotiate the barriers of entering into the higher education systems of the nation.

>> Although high technology educational delivery systems are available to aid onsite allied health education for rural American, delivery systems development of curriculum and software design and educational flexibility lag with a resulting unfulfilled need for rural allied health education.

> With the severe shortage of adequately trained care givers, the humane side of health care is often neglected. Human dignity is often sacrificed just to get the job done.

> Basic oral hygiene services are often neglected with a dramatic effect on patient well being.

> Care of the elderly especially in the inadequately staffed and equipped facilities of rural America is a difficult task with low financial and psychological rewards. Care suffers because of the resultant mind set of the care givers.

POSSIBLE SOLUTIONS FOR IMPROVEMENT

- Networking for interchange of personnel and equipment between the often competing elements of the rural health care system--hospitals and nursing homes.
- Onsite training programs for rural health care workers.
- Increased development of high technology education in providing rural, onsite training.
- Incentives to colleges and universities for increased flexibility in student recruitment, admissions, educational delivery and student evaluations for the preparation of rural health workers.
- Increase payment incentives for home maintenance and care by allied health workers, including family training for care by allied health practitioners.
- Onsite rural teacher training for allied health practitioners to enable them to act as faculty for rural health worker preparation.
- Incentives for interdisciplinary training between nursing and allied health practitioner in the rural health care setting.
- Modification of state dental practice acts to allow oral hygiene care by dental auxiliaries in the rural setting.

Item 15

ASHA American Speech-Language-Hearing Association
10801 Rockville Pike • Rockville, Maryland 20852 • (301) 897-5700 (Voice or TTY)

August 5, 1988

Chris Jennings
c/o Senate Special Committee on Aging
Senate Dirksen Ground Floor
41 U.S. Senate
Washington, D.C. 20510-6400

Re: Special Committee on Aging hearings on rural health care

Dear Mr. Jennings:

I enjoyed speaking with you and I appreciate your interest in the needs of communicatively impaired individuals in rural populations. The American Speech-Language-Hearing Association (ASHA) is the professional and scientific organization that represents over 55,000 speech-language pathologists and audiologists nationwide. We are well aware of the barriers to health care service delivery in the rural areas; these barriers are well documented for speech-language pathology and audiology services. In fact, ASHA has formed an Ad Hoc Committee on Services to Remote/Rural Populations to address these very issues.

The enclosed information will provide you with background information on the demographics of speech, language, and hearing disorders, and access to speech-language pathology and audiology services in specified remote/rural areas. We will hope to provide testimony on these issues, as you suggested, within the 1 week time frame.

You may hear from either Dr. Steven White, Director of ASHA's Reimbursement Policy Division, or Dr. Roger Kingsley, Director of ASHA's Congressional Relations Division regarding the testimony. I will follow-up on any additional assistance that we can provide to you after may vacation which ends on August 17th.

Sincerely,

Carol Frattali

Carol Frattali, Ph.D.
Assistant Director
Reimbursement Policy Division

Enclosure

REMOTE/RURAL POPULATIONS

Demographic Overview

Demographers use a large assortment of terms to describe how populations are distributed. In examining census publications, one encounters terminology such as metropolitan, nonmetropolitan, suburbs, exurbs, city, country, community, centers, rural, Standard Metropolitan Statistical Areas (SMSAs), territory, town, region, settlement. Even the term, "place" has a technical meaning - and remote "places" are sometimes referred to by demographers as "nowhere."

Despite all of this terminology, demographically, two factors distinguish rural areas from other types of population distribution. The first is spatial density of the population. Rural populations tend to be sparse with communities of less than 50,000 people. The second factor is remoteness from the arena of daily metropolitan activities. In rural areas, less than 10% of the workforce commutes to metropolitan jobs.

Twenty-five percent of the U.S. population is considered rural. The conventional images of rural America are of farmers, share croppers, wooden shanty houses with adjacent out-houses, large families of poor, uneducated people and sedentary leisure time. To the contrary, rural areas are geographically and culturally diverse, including such extremes as the Great Plains, the Deep South, Northern Pennsylvania (Appalachia), Northern New Hampshire and Vermont, Alaska and Hawaii, and U.S. territories such as Puerto Rico, the Virgin Islands and the Pacific Trust Territory of Guam. Today, there are 1952 rural counties that represent most of the nation's open country. There are over 42 million people living in these rural areas. Over 90% of the rural dwellers live and work in the immediate rural area.

Most of America was considered rural prior to the Industrial Revolution. As cities were built to support industries, rural populations were lured to them to learn the new industrial way of life. This migration trend continued throughout the 19th and early 20th centuries.

Source: American Speech-Language-Hearing Association, 1985 National Colloquium on Underserved Populations.

Demographers describe a characteristic trend associated with that migration. Migrants from rural areas are typically younger, better educated and employed in more prestigious jobs than their counterparts who remain. The effect is that rural areas tend to lose that segment of their population in which they have invested the most in the form of education and job training and which is in the prime childbearing period. Thus, it can be said that this migration has resulted in the continual loss of "human capital."

In recent years, demographers have noticed an interesting reversal of the urbanization trend. Transportation and communication technology have eased the requirement for urban concentration. Part of the growth of nonmetropolitan areas is attributed to the urban sprawl, that is, spillover from the cities into outlying or suburban areas. Between 20 to 100% of the people who work in cities commute from those outlying suburban areas.

A growing number of people, however, are moving beyond these adjacent areas to more remote nonmetropolitan areas. Unlike the poor and uneducated character of rural America, those who are leaving the city for rural areas are a relatively affluent and well-educated group of urbanites. They include: mining engineers, resort managers, young professionals, retired executives, artists and craftsmen, affluent part-time commuters, returning natives, and some speech-language pathologists and audiologists. These new migrants represent a wide age range and are largely White. Therefore, in future generations, the conventional character of remote locations may drastically change.

Micronesia encompasses a remote territory of the United States which is characterized by extremes in climate, poverty, isolation and culture located outside of the United States mainland. Within the continental United States, the Appalachian region is also characterized by extremes in topography, poverty, isolation and culture. Certainly, all of the problems associated with service to a rural community are exemplified by these different remote/rural locations.

REMOTE/RURAL POPULATIONS: A PERSPECTIVE FROM APPALACHIA

Kathryn H. Chezik
Marshall University

Geographic Overview

It seems somewhat ironic that a part of the United States located in an area entirely surrounded by the rest of the country, and without any official or well-defined boundaries to separate it from the rest of the nation, could be considered a remote area. Yet, in fact, almost everyone with even a passing acquaintanceship with Appalachia would agree that it is indeed a remote area--a distinct entity removed in many ways from the rest of the country.

Used in a geographical sense, the term Appalachia refers to the portion of the mid-eastern region of the country encompassed by the Appalachian Mountains. This area is generally considered to include West Virginia, the eastern thirds of Kentucky and Tennessee, and adjacent parts of other states, including Ohio, Virginia, North Carolina, and South Carolina. Although delineations vary somewhat, all consider West Virginia to be the only state lying entirely within the region.

Despite the fact that the Appalachian region is divided by a number of state boundaries, it remains a single entity. The original reason for this fact is undoubtedly geographic; the region consists of a continuum of virtually uninterrupted mountain chains and hills, making access difficult. From this geographic isolation has developed a distinct culture and dialect, rich in heritage and tradition, and less subject to outside influence, both positive and negative, than other parts of the country.

Much of Appalachia is rural and thinly populated. Unlike many other rural areas of the country, however, the rugged terrain and poor roads make many of the areas virtually inaccessible. Newcomers to the area are surprised to hear distances between areas given in time units rather than in mileage. Because of the varying terrain and secondary road conditions, distances expressed in miles have very little meaning.

Urban areas are few, and cities are small in comparison with other areas of the country. Huntington, for example, the largest city in West Virginia, has a population of less than 65,000.

It is well-known by the rest of the nation that a large percentage of the Appalachian population is poor and undereducated. The economic base is poor, and unemployment in the region is among the highest in the nation. The area is losing population as more people, particularly the younger ones, are leaving the area in greater numbers than people of any age are arriving to settle. There is less mobility even within the region than in most other parts of the nation. People tend to marry and settle in the areas in which they were born and reared. Contact with the rest of the country, especially in the rural areas, may be minimal, except through media. Resources, particularly economic, are limited, and problems and needs are great.

The problems relating specifically to the delivery of services for the communicatively impaired population in Appalachia have not, to my knowledge, been previously addressed. In many ways they are similar to the problems in other parts of the country, although they probably exist in this region to a greater degree than elsewhere. In other ways, however, they are distinctly different. In general, the problems in Appalachia which need to be addressed by our profession include those of high incidence of communication disorders, fewer resources, and factors affecting efficiency and effectiveness of service delivery.

High Incidence of Communication Disorders

As the boundaries of Appalachia are neither official nor well-defined, incidence/prevalence data for communication disorders are not available specifically for the region. However, inferences which can be drawn from available information and the clinical impressions of speech-language pathologists and audiologists who have worked in Appalachia for many years suggest that a higher incidence of communication disorders in this population is probable.

Data which suggest a higher incidence of communication disorders in the school-age population in West Virginia are available for the 1983-84 school year. The percentage of the state's school-age population who were identified as communicatively disordered and receiving speech and language services was 3.26 compared to the national percentage of 2.77 (West Virginia Department of Education). These data do not take into account, however, those children who were identified but not receiving services and those children who were not identified. Obviously the true picture of incidence for Appalachia and the nation as a whole cannot be seen without such data.

Many speech-language pathologists working in Appalachia believe, however, that a higher incidence and greater severity of medically related communication disorders exist compared to the rest of the country. Again documentation is difficult. Direct evidence from caseloads of speech-language pathologists is misleading, as it is believed that large numbers of communication-disordered individuals are never referred to or seen by speech-language pathologists. It is not uncommon, however, for public school speech-language pathologists in some areas to find children in their schools with unrepaired clefts of the palate, severe malocclusions and untreated dental and orthodontic conditions, and severe undiagnosed hearing losses.

Clinicians in this region also believe that the incidence of children with moderate and severe articulation and language disorders is above the national mean. Although a higher incidence of otitis media in Appalachia has not been verified, it has been well-documented that the incidence of otitis media in low socioeconomic groups is significantly higher than in high socioeconomic groups, as much as six times higher according to some studies (Paparella, 1982; Pashley, 1984; Payne & Paparella, 1976). This could easily contribute to a higher incidence of language disorders in Appalachian children, as the link between chronic otitis media and language delay has been strongly suggested (Brandes & Ehinger, 1981; Downs, 1980; Katz, 1978; Mustain, 1979; Needleman, 1977; Ruben & Hanson, 1979.)

Poor health care is probably a major contributing factor to the high incidence of communication disorders. In many areas of Appalachia, as is typical of economically deprived areas, health (medical, dental, and nutritional) care is inadequate. Availability of quality medical care, including prenatal care and preventive health information and advice, is virtually nonexistent in the more rural areas, and access to the metropolitan areas where such care may be available is often not possible. Additionally, as in any low socioeconomic area where economic survival is the highest priority, medical care is frequently viewed as necessary only in life-threatening situations and, therefore, not sought or continued for any other reason. For these reasons, essential medical treatment and follow-up, as well as preventative health care information—even when available—are frequently not received, utilized, or continued.

It is the view of many health care professionals that the incidence of cardiovascular disease and some cancers is higher in Appalachia than in other areas, although confirmation of this is difficult because many of those so afflicted do not receive medical treatment. The higher proportion of the elderly population in this region could also logically contribute to a high incidence of age-correlated conditions. These factors could account for the apparent higher incidence of acquired aphasia and laryngectomy clients.

Studies are greatly needed to compare the incidence and severity of communication disorders in Appalachia to those of the nation as a whole and to determine factors accounting for the differences, if any are found.

Fewer Resources

As might be expected in an area with a low economic base and largely rural population, fewer available resources severely limit the adequate delivery of services to the communicatively impaired population.

Limited Funding

The educational expenditure per pupil in the public schools of Appalachia is among the lowest in the nation. Among the obvious results of such limited funding are an inadequate number of speech-language pathology and audiology positions to serve adequately the needs of school-age communicatively impaired children and noncompetitive salaries for the positions that do exist.

The economic conditions resulting in reduced personnel and low salaries in Appalachia schools extend as well to hospitals, clinics, rehabilitation centers and other traditional sites of employment for speech-language pathologists and audiologists. Despite the critical need for services, private practitioners with successful practices are few, because of the financial limitations of those in need of those services. Certainly, these are problems that exist throughout the nation; it is the greater extent to which they exist in Appalachia that is of critical concern.

Personnel Shortage

Even when positions are funded and available, they may be difficult to fill, particularly in the rural areas. The pervasive negative stereotypes of Appalachia which exist throughout the rest of the country make it especially difficult to recruit qualified professionals to this area, despite its unspoiled beauty and self-reliant people.

To their credit, many agencies and school systems are making valiant efforts to attract and keep qualified speech-language pathologists and audiologists. Some are even offering inducements much like those offered to professional athletes, such as cash bonuses upon signing a contract and additional bonuses for returning a second year (see Appendix A).

Despite such efforts, there is still a critical shortage of qualified personnel to fill the available positions. Training programs in this region are inundated with requests from employers seeking qualified speech-language pathologists and audiologists for their programs. A letter from the coordinator of communication disorders from the West Virginia Department of Education attests to the need for additional speech-language pathologists (see Appendix B).

The need for additional audiologists is at least as great. Using data provided by the Bureau of Education for the Handicapped, ASHA (1980) estimated that in order to serve adequately the needs of the hearing-impaired population in the schools of West Virginia, the number of audiologists employed by the schools would need to double. If the ratio of 1 audiologist to every 75 hearing-impaired children recommended by Ross and Calvert (1977) were used, however, the number of audiologists employed would need to be increased by over 350%. These projections are based only on the number of children with identified hearing loss. If all those with unidentified or fluctuating hearing losses could be included, the numbers would undoubtedly be far higher.

The critical need for additional speech-language pathologists and audiologists in Appalachia is apparent. Funding for additional positions must be secured and more effective recruiting efforts must be made if this need is to be met.

Inefficiency and Ineffectiveness of Delivery of Service

A significant problem in delivery of speech, language, and hearing services in rural areas such as Appalachia is one of population distribution.

Accessibility

Even if the number of speech-language pathology and audiology positions funded and filled in this region were adequate to meet the needs of the communicatively impaired population, access to these services would still be limited. The majority of service providers are clustered in the few urban areas, whereas the majority of those requiring their services are located in outlying areas, often without personal or public transportation.

The motivation to seek speech, language, and hearing services is significantly and understandably lessened when these services are not available within proximity of home and transportation is not readily available. In many parts of Appalachia, those in need of speech, language, and hearing services have virtually no access to the services that do exist.

The alternative solution of sending the provider to the consumer is usually not practical. The common practice in the public schools of having speech-language pathologists serve several schools on an itinerant basis is cost-effective in areas where distances between schools is minimal. In rural areas of Appalachia, however, travel time between schools may be so great that it actually equals or even exceeds the time spent with the children. The same situation exists for speech-language pathologists, such as those employed by county home health programs, who provide diagnostic and therapy services to home-bound clients.

Speech-language pathologists and audiologists working in rural Appalachia feel, and often are, isolated physically from each other and from other health care professionals. The "team approach" to multifaceted communication disorders which may be considered standard practice in many parts of the country is not possible in most Appalachian areas because of geographical constraints. Professional contact and communication between and among speech-language pathologists and audiologists and other health care providers is limited and, in some areas, nonexistent. Infrequent interaction among professionals results in less frequent and appropriate referrals and consultation. It also reduces professional awareness and understanding of the roles and responsibilities of each profession, which inevitably has a negative effect on client care.

Lack of Public Awareness

Delivery of speech, language, and hearing services is also hindered by lack of public awareness both of the importance of communication and of the existence of services for the communicatively impaired. Clinicians working in Appalachia frequently express the opinion that this problem is significantly greater in this region of the country, and results of a survey of rural public awareness of speech-language pathology and audiology conducted in West Virginia (Killarney & Lass, 1981) lend support to this position. Almost half (46%) of those surveyed did not know that the "professional who provides help for people who have speech or language problems" was called a "speech pathologist" or "speech therapist." Killarney and Lass concluded that "the rural population sampled had limited information and awareness of the professions" (p. 416). Their sample population consisted entirely of people living in Monongalia County, West Virginia, a county on the northern tip of Appalachia with a major university contributing heavily to its population. All their respondents had telephones, a third were university students, over half had some education beyond high school, and only 3% were unemployed. As these results were obtained from respondents representing the high end of the educational and socioeconomic continuum in Appalachia, it seems very likely that the problem of public awareness regarding speech-language pathologists and audiologists in the heart of Appalachia is even greater than the results of this survey would indicate.

Clinicians working in these areas report that they have neither the time nor the resources to overcome the problems resulting from lack of understanding of the importance of the services they provide. Public school clinicians who have also worked in other parts of the country report that in Appalachia attendance for parent conferences is poorer, permission for diagnostic and therapy services more difficult to obtain, and recommendations for referral and homework less frequently followed. Clinicians express frustration with these circumstances, despite understanding the cause. One clinician expressed it succinctly: "These parents care about their children, but they have other things on their minds, like survival!"

For many clinicians, however, the challenge becomes overwhelming. Miller and Potter, (1982) in their discussion of their study of "professional burnout" among speech-language pathologists, suggested that major contributing factors are "strong feelings of job ineffectiveness and dissatisfaction" and work "in a setting where there are at best minimal facilities and resources to help cope with or alleviate factors associated with burn-out" (p. 180). In Appalachia, such conditions are common and "professional burnout" is the frequent result. Many clinicians leave the area and sometimes the profession. High turnover in personnel negatively affects the continuity of the program and the morale of those who remain.

Appalachian Dialect

An additional factor contributing to the difficulties of delivery of speech, language, and hearing services in Appalachia is the complex issue of dialect. Although social dialects and their implications have been at the center of a storm of controversy and confusion in our profession for several decades, the recognition of social dialects as rule-governed language systems has now been firmly established. ASHA's acknowledgment of the linguistic validity of social dialects as legitimate variants of the English language as expressed in the position paper prepared by the Committee on the Status of Racial Minorities (1983) is a positive step toward reducing the misinformation regarding dialects within the profession. Unfortunately, however, our profession's recognition that social dialects are not substandard forms of the language has not yet generalized to the society as a whole and has had little effect on the stigma society places on some social dialects and on those who speak them.

Yet, despite the increased focus on social dialects by ASHA, Appalachian English has received relatively little attention from our profession. Despite a comprehensive study of Appalachian English by Wolfram and Christian (1976), speech-language pathologists, even those employed in Appalachia, have little understanding of the dialect's phonological and grammatical features. Many of these clinicians are themselves speakers of Appalachian English, and some still accept society's viewpoint that they are speakers of "substandard" English. These clinicians are, quite understandably, not comfortable about their ability to differentiate speech and language disorders from dialect differences, and feel unprepared to serve the needs of nonstandard English speakers who elect to learn standard English.

Few resources are available to help them. Courses in sociolinguistics or social dialects, with particular emphasis on Appalachian English, are virtually nonexistent in speech-language pathology training programs. Published materials are just as rare; of over 220 published materials listed in ASHA's Resource Guide to Multicultural Tests and Materials (Cole & Snope, 1981) and in its Supplement I (Cole & Campbell-Calloway, 1983) and Supplement II (Deal & Yan, 1985), ranging from Eskimo to Vietnamese, only one (Wolfram & Christian, 1976) deals specifically with Appalachian English. It is apparent that we need to increase our knowledge of Appalachian English and develop and disseminate more materials and resources for our clinical use in working with speakers of this dialect.

Summary

The difficulties in the delivery of speech, language, and hearing services in Appalachia are many, and they have been overlooked for too long. Clearly, if we as a profession claim to be able to serve the communicative needs of the people in Appalachia, we must prepare ourselves more adequately to address directly the problems and challenges that await us there.

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APPENDIX A

2/1/85

McDowell County Public Schools

WELCH, WV

WANTED FOR THE 1985-86 SCHOOL YEAR

SPEECH PATHOLOGIST

SIX NEW OPENINGS

$2,000. cash incentive to sign.

$15,670. -- STARTING SALARY, MA DEGREE, 10 MONTHS

$400. cash allowance for instructional materials.

Travel allowance.

Maximum caseload - 40.

Paid expenses to state convention.

Two weeks summer employment available.

Opportunity to contract work after hours ($18. per hour).

$1,000. cash incentive at completion of year if returning.

APPLY WITH:

Michael Cortellesi, Coordinator of Personnel
McDowell County Public Schools
30 Central Avenue
Welch, WV 24801

Phone: 304-436-8441

We invite you to
visit our county
April 29 - May 3

APPENDIX B

State of West Virginia
Department of Education
Charleston
25305

ROY TRUBY
STATE SUPERINTENDENT
OF SCHOOLS

February 5, 1985

Ms. Kathryn Chezik, Acting Director
Speech Pathology Program
Smith Hall Speech and Hearing Center
Marshall University
Huntington, West Virginia 25701

Dear Ms. Chezik:

The State of West Virginia has been experiencing a grave shortage of certified speech-language pathologists for employment in the public schools. This shortage even exceeds that which has been reported for math and science teachers. Currently, at least 27 vacancies exist for which counties have funds available but are unable to hire speech-language pathologists. Some counties desire to create additional positions to serve identified communication disordered students but are unable to do so because of the shortage of qualified personnel.

On behalf of county special education directors and the students they serve, I strongly urge you to do all that you can to recruit students into Marshall University's training program. Please know that your efforts in this matter are greatly appreciated.

Sincerely,

Patricia M. Clark

Patricia M. Clark
Coordinator, Communication Disorders
Office of Educational Program
Development

PMC/vh

0029R

REMOTE/RURAL POPULATIONS:
A PERSPECTIVE FROM MICRONESIA

Jean Lee Stewart
Bureau of Family Health Services
Territory of Guam
and
University of Guam

Introduction

Remote is defined as "far removed in space, time or relation." Few words could more vividly describe the peoples, places, and problems which will be addressed in this paper. The single most striking characteristic of Micronesia (which means tiny islands) is appropriately the smallness of the islands surrounded by the vastness of the ocean. The limited land area separated by vast expanses of water have always been obstacles to trade and mobility, but they are no less effective barriers to the provision of services to people with communication disorders.

Figure 1 represents the last area of Micronesia superimposed on a map of the United States. Micronesia is a geographic designation for one of the three principal divisions of Oceania, Melanesia and Polynesia being the other two. This is an areas of about 3 million square miles, the size of the continental United States. But collectively these 2,000 islands and atolls comprise a total land area of only about 700 acres, an estate smaller than half the size of Rhode Island. The islands are remote not only from one another within the immense expanse of ocean, but the great distances that separates the region as a whole from the nearest resource-rich, large population center creates another whole dimension to remoteness.

Historical Perspective

Since the mid-seventeenth century Micronesia, has been subjected to violent change imposed by the domination of four successive foreign rules: Spain, Germany, Japan and finally the United States. Spain ruled under the influence of Medieval Catholicism; Germany, by economic imperialism; Japan through military and economic exploitation; with the United States' floundering from apathetic paternalism influenced by strategic military considerations.

Guam has been a territory of the United States since 1892 when it was one of the spoils of the Spanish-American War. It has remained under the American flag except for a three and one-half year period during World War II in which it was the only American territory under Japanese occupation. It is a single island, populated by about 125,000 people. Although Guam is geographically part of Micronesia, developmentally, culturally and politically, it is separate and unique.

By contrast, the other islands of Micronesia did not come under American influence until after World War II when they became a Strategic Trust of the United Nations to be administered by the United States.

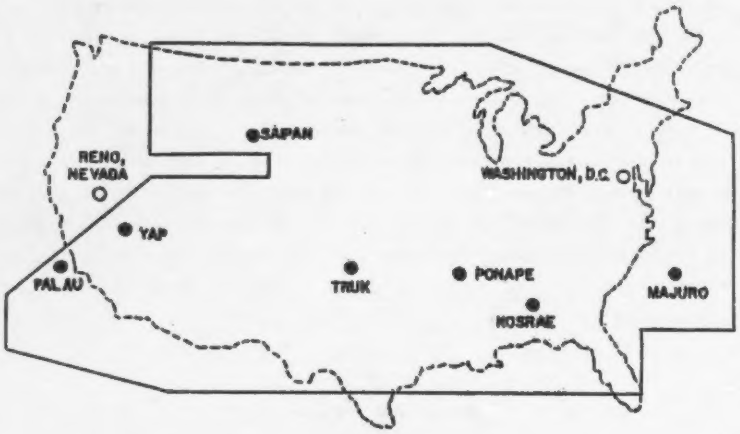

Figure 1. Distance Comparison Between Mainland USA and the Trust Territories of the Pacific/Commonwealth of the Northern Marianas

Identified Service Needs

Services by members of the profession of speech-language pathology and audiology have been available to this Pacific Basin population on a very limited basis for the past 15 years. Services on Guam began in 1968 in response to the rubella epidemic which swept across the Pacific after wrecking its havoc on the Mainland. In the fall of 1964, Guam had an epidemic of German measles, which resulted in a significant increase in fetal wastage in the closing months of the year. In the spring and summer months of 1965, tremendous morbidity was encountered with the births of large numbers of rubella deaf children. Over 150 deaf and 6 deaf-blind children were the result of that epidemic. This represented a full 5% of all the births for the year. Rubella has been shown to be especially devastating in island populations where there is limited immunity.

Another factor encouraging the development of services was the high incidence of otitis media. Eldridge, in an article published in Archives of Otolaryngology in 1970, stated of 1,311 Guamanian school children screened for hearing loss, 259 (16.5%) had a hearing loss greater than 20 decibels. Otoscopic examination of 157 of the latter indicated 79 (50.3%) had evidence of otitis media and an additional 13 (8.3%) had perforation. These rates are among the highest that have been reported for deafness, otitis media and perforation. (p. 152-153) These dual service demands let to the establishment of the Hearing and Speech Center within the Department of Public Health and Social Services in 1968. Also that year, an operating microscope was ordered through Crippled Children's Services to begin the first civilian ENT Program. Although the incidence of chronic ear disease has been significantly reduced, otitis media continues to be a major problem, as these data from the Guam Crippled Children's Program show. ENT problems account for more than a third of the CCS caseload. Although the national average of ENT caseload within a Crippled Children's Services Program was 9%, on Guam it was 37%.

TABLE 1. Guam CCS Program Caseload Percentages.

Condition	U.S.(1971)	Guam (1971)	Guam (1980)
Cardiac	9	14	14
ENT	9	20	37
Eye	29	13	14
Neurological	8	15	21
Ortho	29	12	14

Services actually began in the Trust Territory in the same year. A husband and wife team traveled throughout the districts in 1968, funded by a Title VI project to do hearing and vision screening as a beginning of special educational services to the children of the isolated islands. Since the Trust Territory Crippled Children's Program was operated by Guam at that time, audiological services were first provided that year for a very limited number of children in the Trust Territory. It soon became evident that the results of the rubella epidemic and the high incidence of otitis media were in no way limited to Guam but characteristic of the entire Pacific Basin area.

There are limited, current prevalence and incidence data available. There have been no opportunities for large-scale screening and identification activities by clinicians who are contracted essentially to provide clinical diagnostic services. But there are things we know. We know that there are still rubella deaf children on each of the islands. We do know that the incidence of otitis media is extremely high, among the highest in the world. For the Commonwealth, as reported in their health plan, diseases of the ear and mastoid process were the fourth ranked cause of outpatient treatment at the district hospital for 1978 and 1979.

The active Crippled Children's registry of the Trust Territory for 1976-77 showed that ENT problems represented one fourth of the total Crippled Children's Services caseload, with the asterisk that there are actually more cases than this--because most are treated at the district level and not even reported to headquarters. It is important also to realize that these data almost exclusively refer only to children in the district centers, not to those living on the outlying islands.

The island of Palau is without a doubt where the highest rates exist for middle ear disease throughout Micronesia. The Head Start screening showed that in 1981, 33% of the children had definite ear disease, with 15% having one or more perforations.

In an audiological assessment of Palauan Head Start children in 1982, 17% were certified as hearing handicapped. An additional 26% of the children were certified as health handicapped, generally due to a serious unilateral hearing loss.

In 1983, similar audiological assessments resulted: 38% were certified as hearing handicapped and 35% were certified as health handicapped. There were obvious or known unilateral perforations in 16% of the children, with bilateral perforations in 6% of them.

Similar patterns are found on other islands. For example, in 1982, 57% of the Marshall Islands Head Start children were found to have middle ear disease, 52% had serous otitis media, and 4% had otitis media with perforations. Additionally, the incidence of cleft palate is also considered significantly higher than elsewhere.

Service Delivery Obstacles

There are numerous problems peculiar to this region which create difficulties in delivering professional services to this population. They include level of development, medical barriers, cultural patterns, climate, limited prevention services, population distribution, paucity of professionals, age of the population, cultural transition, geographic barriers, attitudinal barriers, environmental barriers, political barriers, and language barriers.

Level of Development

In the early years of American Administration, it was official policy to keep Micronesia out of the mainstream of the twentieth-century world, a policy popularly known in Micronesia as the "zoo philosophy" prevailed. Anthropologists desired to see the island cultures remain unchanged. Little impact was made during the first two decades of American administration on medical care or educational services. Little attention was given to the development of infrastructure or self sufficiency. The legacy of the past continues to haunt us today.

Much of the travel between the various Head Start Centers is by boat--audiometric equipment has be be carefully wrapped in plastic bags. After arriving by boat the equipment frequently has to be transported a considerable distance on foot to the Head Start Center. The most common type of construction for Head Start programs throughout Micronesia--plywood with corrugated tin roofs. The interior of the classrooms are drab by stateside standards, with usually only natural lighting available. The Centers are almost all without tables and chairs and other furniture. There are limited teaching materials.

Much of the work is done by the clinicals out of doors using natural foliage for seating. Sometimes there was not even an appropriate place to test out-of-doors, so audiological testing has been done in the vehicle at times.

Screening and testing is never done in privacy--all the neighborhood will frequently come to watch what the visitors are doing. The whole families come along. Frequently, at least for audiology, there is the opportunity to screen all the children in the family on the same day.

Medical Barriers

Professional medical standards are unlike those on the U.S. mainland. The backbone of the Micronesian Medical System is not the medical doctor, but the medical officer. These are islanders who received 5 years of postsecondary (Micronesian level) medical training in Fiji back in the 50s and 60s. There are very few U.S.-trained doctors, except for National Health Service Corps physicians recently assigned to the area. The bulk of health care, especially outside the district centers, is provided by health assistants, nurses, or medics. There are no otolaryngologists, no plastic surgeons throughout Micronesia, with the exception of Guam.

In 1984, at the request of Congress, an intensive study has been conducted to determine the current status and evaluate the effectiveness of federal support to the health systems of the Pacific territories. This study is intended to assist policy makers in developing future standards to improve health and health care delivery systems. The initial findings have been dismal. The health problems facing the region have been categorized as those of manpower, management, materials, maintenance, medical referral, mission, mass, morale, and money.

The development and provision of skilled and competent health personnel will remain for a long time as a major need and problem. The inadequacy of primary and secondary educational opportunities which exist in the region makes it difficult for local citizens to compete successfully in educational opportunities abroad.

Cultural Patterns

Many of the failures within the system can be attributed to inability to utilize modern administrative, managerial, and supervisorial methods. Family and kin ties, village and extended family authority patterns, and cultural loyalty are all cherished institutions which provide an invisible overlay to the Western style of management and administration. Long supply lines create constant crises in assuring adequate drugs and other supplies to operate a health care system.

Climate

Because of climatic conditions (heat, salt air, and high humidity) which are unalterable, materials simply do not last as long in the islands. The useful life of equipment is estimated to be less than 50% of what it would be elsewhere. Due to limited local resources, the local governments have had to depend on off-island medical referrals to meet most of their specialty care needs.

The fact is especially meaningful for audiologists as they seek to maintain delicate, expensive audiological equipment. There are no repair resources in the region. Equipment has to be sent either to Hawaii or the mainland. Frequently the return trip through the multitude of carriers and varying levels of climactic exposure, leaves the equipment still in need of repair.

Limited Prevention Services

The islands struggle to provide preventive, primary, and limited secondary services. Prospects for their entry into even superficial tertiary care are nearly nonexistent. A certain mass (resources, based on size) is required to provide complete health services. The small populations, remote in location, do not have sufficient mass to provide the resources for more complete health care. The U.S. during its administration has tended to build expectations that not only are Pacific Islanders deserving of first-rate, comprehensive Western medical care, but that the goal is attainable. However, federal financial support has tended to be categorical and fragmented. Local government priorities, under conditions of limited economic development, will not be high for health service support. There will be insufficient local money to support even basic services.

Population Distribution

To look at total numbers of people is misleading in assessing need for health services. For example, the Federated States of Micronesia, including Yap, Truk, Ponape, and Kosrae, occupy an area 2,000 miles from east to west and 1,000 miles from north to south. But only approximately 75,000 people live in this area. Nearly 50 of these islands have populations of less than 1,000—most of them in the 200-500 range—usually separated by a hundred or more miles from the next small group and many hundreds of miles from the main center where health services are available. The possibility of regionalization is limited by the huge distances and expensive transport between centers—a difficulty compounded by different cultures and languages as disparate as Italian and Norwegian.

The sharply limited population base in each of these different areas is a dominant factor in determining what medical and health services can be provided, in both a qualitative and quantitative sense. There is a critical mass—a minimum number of people—for which deployment of various kinds of health practitioners and provision of various more or less sophisticated services can rationally be justified.

The islands of Micronesia are not a string of beaches and lagoons that are linked by causeways or accessible by paddling a short distance to the next in the chain. They are, geographically, the most scattered and isolated spots in the world, more so even than the Australian outback or the Alaskan tundra. Further, the groups of people in each scattered place are much smaller. This wide scattering of miniscule populations is not the result of poor planning—it is an absolutely unalterable fact. To ignore this fact in planning for provision of health care can only result in incurring incredibly high cost while still not even approaching the level of health services common in urban or, for that matter, rural America. It is obvious that the pattern for providing health services in small scattered islands must not be based on the notion that what works in New York or Arizona will work in Micronesia.

Paucity of Professionals

Similarly, the educational system is not composed of the same percentage of professionally trained educators as would be found in a mainland community. The vast majority of teaching is done by teachers with no degree, or at the most, with only an AA degree. For example, in the Marshalls, 70% teach with no degree and only 1% have a BA degree.

When the preparation of special education teachers is examined, a similar pattern emerges. In the Northern Marianas, for instance, 75% of the personnel in special education have only an AA degree. There are virtually no psychologists, nutritionists, social workers, or other members of the multidisciplinary team we have come to rely on as professionals. In view of the foregoing levels of professional preparation in health and education, it is probably not reasonable to expect that services in the field of communication disorders will be provided by master's level trained clinicians in the foreseeable future.

Age of Population

Micronesia is composed of young people. It has one of the world's youngest median ages—15.3 years. The population is expected to double by the year 2000. The great majority of Micronesians (more than 75%) are less than 30 years of age. Of special significance is that 72% of all females are less than 30, which results in high fertility rates. Micronesia has one of the world's highest growth rates, 4.6 percent between 1967-1973 compared to a 2.6 percent rate for Africa, a 2.7 percent rate for Latin America and a 2.5 percent rate for Southeast Asia.

This growth rate, alone, speaks to the increasing need for services for communicatively handicapped children, given even that the incidence of disorders would be no higher within this population than within a comparable mainland population.

Cultural Transition

Not only does this area represent many different cultures, but it embraces a group of societies in rapid transition. It must be emphasized that here is a group of cultures clustered under the name of Micronesia--that all of them are changing, though the rates of change vary from island to island.

Unfortunately, prejudice is no stranger to the cultural scene here in these islands. One eminent Micronesian is quoted in Micronesia at the Crossroads, "We hate each other more than we hate the Americans." Strong class systems abound. These are traditional societies with all the attitudes, values, and institutions inherent therein. The rapid transition produces value clashes between the old and young people of the culture. Educated, no longer content with the old ways, but without access to jobs and money to support a Westernized life style, there is conflict between the generations, rising rates of alcoholism, drug abuse, and suicide.

Geographic Barriers

Geography provides a prime obstacle to service delivery. Persons in Washington, DC, accustomed to having three international airports within an hour's drive with daily flights that can immediately link them with every part of the nation and world, may be unappreciative of the travel restrictions imposed by Oceania.

In Micronesia there are two choices for travel--by air or by sea. Table 2 includes minimum and maximum distances from district centers to outer islands of each district. It may give some appreciation of the logistical problems encountered in service delivery to all the population. But to understand the full impact of the travel problems, it is important to appreciate the percentage of the population which actually lives on the outer islands. Considering the area in total, almost one half lives on either an intermediate or an outer island.

TABLE 2. Trust Territory of the Pacific Islands:
Average Direct Travel Distances from District Center to Populated
Outer Islands or Island Groups

District	Number of Inhabited Outer Island Groups	Travel Distance from District Center (Miles) Minimum	Maximum
Marshall Islands, Majuro	21	35	687
Palau Islands, Koror	7	30	365
Ponape Islands, Kolonia	6	88	364
Truk Islands, Moen	24	51	202
Yap Islands, Colonia	11	80	620
Kosrae, Toful	0	0	0

Air travel often requires even greater travel times. Planes do not go every day, often not even on the day when they are scheduled. There are no back-up aircraft--If one breaks down, passengers wait for the parts to be flown for repair. To go from the Marshalls to Palau can take 2-3 days, under ideal circumstances. The Marshall Islands are across the International Date Line, which further complicates travel and communication.

Attitudinal Barriers

Attitudinal barriers also exist. In an area with only limited experience with modern medical care, copying mechanisms have been required. Handicapped children are often still hidden as sources of shame. In cultures where there was no otologic intervention available before chronic middle ear disease had led to a brain abcess, there is understandable fear and resistance to the thought of ear surgery for a child. Death has not been an unusual sequel in the past--so why risk it now when the child is hardly sick? Professionals continue to confront problems throughout the area, even in getting surgeries done for cleft palate children.

Environmental Barriers

The environment itself presents a formidable barrier, especially for the practice of audiology. There is generally power only in the district center, with that often undependable and fluctuating. How many audiologists have ever tried to test hearing hooked up to a noisy generator? Audiometers are available in battery models, which can partially resolve the problem, but to date there is no battery-powered tympanometer. The high humidity, heat, dust, frequent rain, and constant body sweat are hardly conducive to good hearing aid function. Just supplying hearing aid batteries is a formidable challenge.

Political Barriers

Political barriers are a reality to be recognized. After generations of essentially foreign occupation, there is now a fierce determination that Micronesia be administered and served by Micronesians. There is real resistance to hiring outsiders to come in and provide any nonessential service. Years of experience with visiting specialists--with far too frequently negative experiences--have created bitterness and resentment. Outsiders expect, demand, and receive more money and benefits than the local people. Even if people from the field with degrees in audiology and speech-language pathology were willing to come, were able to adapt to the developmental differences, survive cultural shock, and successfully function to provide services in another language and culture, they would be unwanted--There are just not enough jobs to go around. An outsider would be utilizing resources that a cousin, sister, or uncle needs. This may be a tough pill for professionals to swallow--but reality it is.

Language Barriers

But perhaps no impediment to service is so pervasive as the attempt to provide services through clinicians not fluent in the primary language of the child. Audiology is relatively free--Pure tones present no language barrier.

But this is not so when speech-language services are considered. When the program began at the University of Guam, the literature was searched for anything that would be of assistance in determining how best to initiate speech/language services. There was precious little written; and everything identified was addressed either to the needs of Hispanics or American Blacks. No guidelines could be located to provide guidance to begin providing services to a multilingual, multicultural population.

For instance, in the Head Start program on Saipan, classroom instruction is delivered simultaneously in three languages. There is the large group of Carolinian children, about a third of the population, who are instructed in their language by Carolinian teachers. Then there are the Chamorro children, another third, who are instructed in their language. Then all the other children, usually represented four or five other primary languages, are instructed in English.

Guam Training Program

Since the fall of 1981, the University of Guam has had a training program funded by the U.S. Department of Education to provide undergraduate training in communication disorders for people from the Pacific Basin. An important component of that project is to provide paraprofessional training in each of the districts to provide speech-language and hearing screening of school children and Head Start children.

Summary

Just as the islands are tiny and the waters vast, so are the available resources very limited and the needs overwhelming. At the present time there is no one in the basin with a terminal degree in communication disorders. There is one young woman from Guam who is currently completing her doctorate in speech-language pathology at the University of Oklahoma. There are five master's level people in audiology, three of whom are living on Guam, two of whom are certified in Audiology. There are five speech-language pathologists (all living on Guam) with master's degrees, two of whom are also certified. There is an audiologist on Palau who was trained at the University of Hawaii.

There are fundamental questions which must be addressed without the possible bias of professional self-interest. In an area without indigenous pediatricians, obstetricians, and otolaryngologists, what is the priority for audiologists and speech-language pathologists? On islands without a sewage disposal system and adequate water supply, what proportion of the available resources should be used to address the needs of the communicatively handicapped? In an environment without dependable power, where it is difficult to maintain an adequate otoscope, what is the relevance of our sophisticated audiological instrumentation? In a system where children needing reconstructive ear surgery have been waiting several years for the visit of an otolaryngologist, what proportion of our resources should be directed toward screening activities.

Yet, in a culture with a strong oral tradition, where culture, stories, mores, and language are handed down by word of mouth, in cultures with limited printed media, cultures not yet inundated by visual images, should not good communication skills perhaps be assigned a higher priority than in other, more advanced societies? There is no question but that the needs exist and that persons with communication disorders are as eager for help as they are anywhere else. But wisdom is required to equitably distribute available resources to meet the most pressing needs. Obviously, these decisions must be made by Micronesians themselves. They must be the decision makers for the allocation of their limited resources. Only through their leadership will they then embrace these decisions with respect and commitment.

I would like to close with this statement from the text, Hearing in Children:

> Since our beginnings in the mid-forties, we have measured, described, researched, catalogued, analyzed and synthesized the entity of hearing loss exhaustively--and now, having defined it, we must busy ourselves with preventing the devastation of its effect on children. In such terms, preventive audiology becomes a viable endeavor--a discipline devoted to preventing the effects of ear disease on the individual who suffers from it. Such prevention can only be accomplished by early detection of the condition and by proper provision for remedial therapy and education. (p. 314)

Nowhere could this preventive approach be better directed than toward addressing the unmet needs of the remote populations of Micronesia. A former Secretary of State is reported to have commented on the area, "There are only a couple of hundred thousand people out there—who gives a damn." Here's hoping that members of our profession do give a damn, do want to serve the underserved, in spite of the barriers and obstacles that exist.

REMOTE/RURAL LOCATIONS

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